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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 473			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					4217 Van Ness			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Neal</u>					4. DATE OF DEATH <u>Dec. 8</u> 19 <u>67</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9 - 1910</u>		9. AGE (In years lost birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. AIR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Ross Neal</u>					14. MOTHER'S MAIDEN NAME <u>Florence Simpson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>U.S. Navy</u>			16. SOCIAL SECURITY NO. <u>351-03-3121</u>		17. INFORMANT <u>Marion Neal</u> Address <u>Same as above</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary thrombosis</u> DUE TO (b) <u>Advanced severe coronary arteriosclerosis</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19 APR, 1959</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1 Dec</u> 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Herbert Martyn Jr</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9 Dec 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>					22d. ADDRESS <u>4740 Chevy Chase Dr N.W.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u> ADDRESS <u>5130 Wisconsin Ave. N.W.</u>					25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div>17319</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>17318</div>									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN TB 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital					d. STREET ADDRESS 4216 Anthony Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Y. Last NEWHOUSE					4. DATE OF DEATH Month December Day 21 Year 19 67				
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1921		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Romney, West Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Newhouse					14. MOTHER'S MAIDEN NAME Zona Shank				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1962			16. SOCIAL SECURITY NO. 232 26 0598		17. INFORMANT Street Kensington, Md. Mrs. Margaret B. Newhouse, 4216 Anthony				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Nov. 7 , 19 67 , to Dec. 21 , 19 67 that (1) (we) last saw the deceased alive on Dec. 21 , 19 67 , and that death occurred at 655 M, from causes and on the date stated above.									
22a. SIGNATURE Lawrence A. Jones M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 21, 1967		
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M. D.					22d. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 12/24/67		23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		23d. LOCATION (City or Town) (County) (State) Romney, West Virginia			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Maryland					25a. REC'D BY REGISTRAR DATE DEC 28 1967		25b. REGISTRAR'S SIGNATURE James Judge		

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Rt # 2 Box 49</u>			
3. NAME OF DECEASED (Type or print) <u>WILFRED Donald NICHOLSON</u>		4. DATE OF DEATH <u>Dec 26 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/18</u>		
9. AGE (In years lost birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal Caretaker</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Comas Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George E. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Whipp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-30-8285</u>			
17. INFORMANT <u>Donald Nicholson Son - Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypokalemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypokalemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1952</u> to <u>Dec 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> 19 <u>67</u> , and that death occurred at <u>8:30 P</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>John G. Fawcett</u> M.D.		22b. DATE SIGNED <u>Dec 27, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/29/67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda Montg - Md</u>			
24. FUNERAL DIRECTOR <u>William B. Hillman</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 2 1968</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY in 1b <u>14 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POOLSVILLE</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES W. NORRIS</u>			4. DATE OF DEATH Month Day Year <u>DEC 20 1967</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/08</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER - NORRIS LUMBER & FUEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>			
13. FATHER'S NAME <u>CHARLES NORRIS</u>			14. MOTHER'S MAIDEN NAME <u>CORA BAUMAN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-09-1672</u>		17. INFORMANT <u>VERA - WIFE - SAME</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis with thrombosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____	21. I certify that (I) (this hospital) attended the deceased from <u>August 18, 1965</u> to <u>12/20/1967</u> , that (I) (we) last saw the deceased alive on <u>12/20/1967</u> , and that death occurred at <u>9:01 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Maccon</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/20/67</u>		22c. PHYSICIAN'S NAME (Type) <u>809 Viers Mill Rd, Rockville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>			
24. FUNERAL DIRECTOR <u>William C. Nutter, Barneville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

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[Faint, illegible handwriting and text throughout the page, possibly bleed-through from the reverse side.]

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN TB <u>admitted 3-1-67</u>		d. STREET ADDRESS <u>121 Bradford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Nwell</u> Last <u>Nwell</u>		4. DATE OF DEATH <u>December 12, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10 1870</u> 97 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac A. Beckett</u>		14. MOTHER'S MAIDEN NAME <u>Susan Milan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-55-4732</u>	
17. INFORMANT <u>Brooks E. Soderstrom</u>		18. ADDRESS <u>9039 Sligo Creek Pkwy Silver Spring, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old age (97)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>12/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>67</u> , and that death occurred at <u>9:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard Delaney</u>		22b. DATE SIGNED <u>12/14/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Delaney</u>		22d. ADDRESS <u>4323 HARVARD ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John E. Jones</u>			

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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17322

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7401 New Hampshire Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Edward</u> Last <u>Noyes</u>				4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-93</u>		9. AGE (in years last birthday) <u>74</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Std. Oil Corp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Noyes</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Duguid</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>578-05-9877</u>		17. INFORMANT <u>Chart</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adams Stokes ATTACKER</u> <u>4-20-1</u> DUE TO (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Arteriosclerosis obliterans</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>						19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>67</u> , to <u>12/16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>67</u> , and that death occurred at <u>11:24</u> A.M., from causes and on the date stated above							
22a. SIGNATURE <u>Benneth C. Crige</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/16/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>12-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				ADDRESS <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Health may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

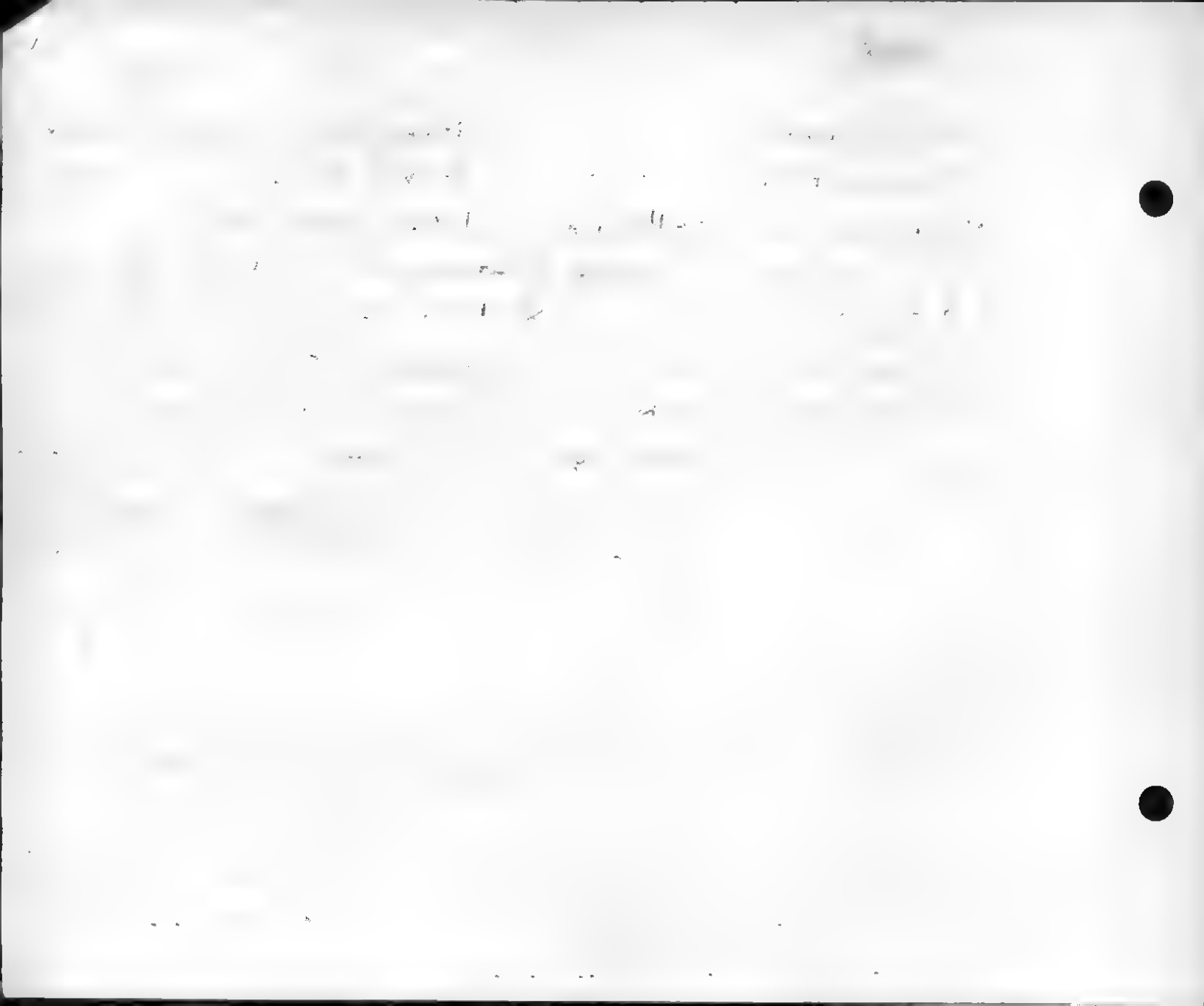
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17323

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		e. STREET ADDRESS 1602 CAREY LANE	
3. NAME OF DECEASED (Type or print) First Middle Last AGNES (NMN) O'CONNOR		4. DATE OF DEATH Month Day Year 12 25 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-6-02
9. AGE (In years past birthday) yrs 65		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK B MARTIN		14. MOTHER'S MAIDEN NAME GRACE McCHESNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-54-7655	
17. INFORMANT Martin O'Connor Address 161 H. St. V. 1, Cal., D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest during surgery DUE TO associated with arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Disease + Arrhythmias DUE TO (c) Heart Disease + Arrhythmias	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED DEC. 26, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		Address (City, town, or county) Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Rock Creek	23d. LOCATION (City or town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Thomas E. Hennessey, Inc. Address 8434 Ga. Ave. S.S. Md		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE Thomas E. Hennessey, Inc.		25c. REGISTRAR'S SIGNATURE	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-233. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

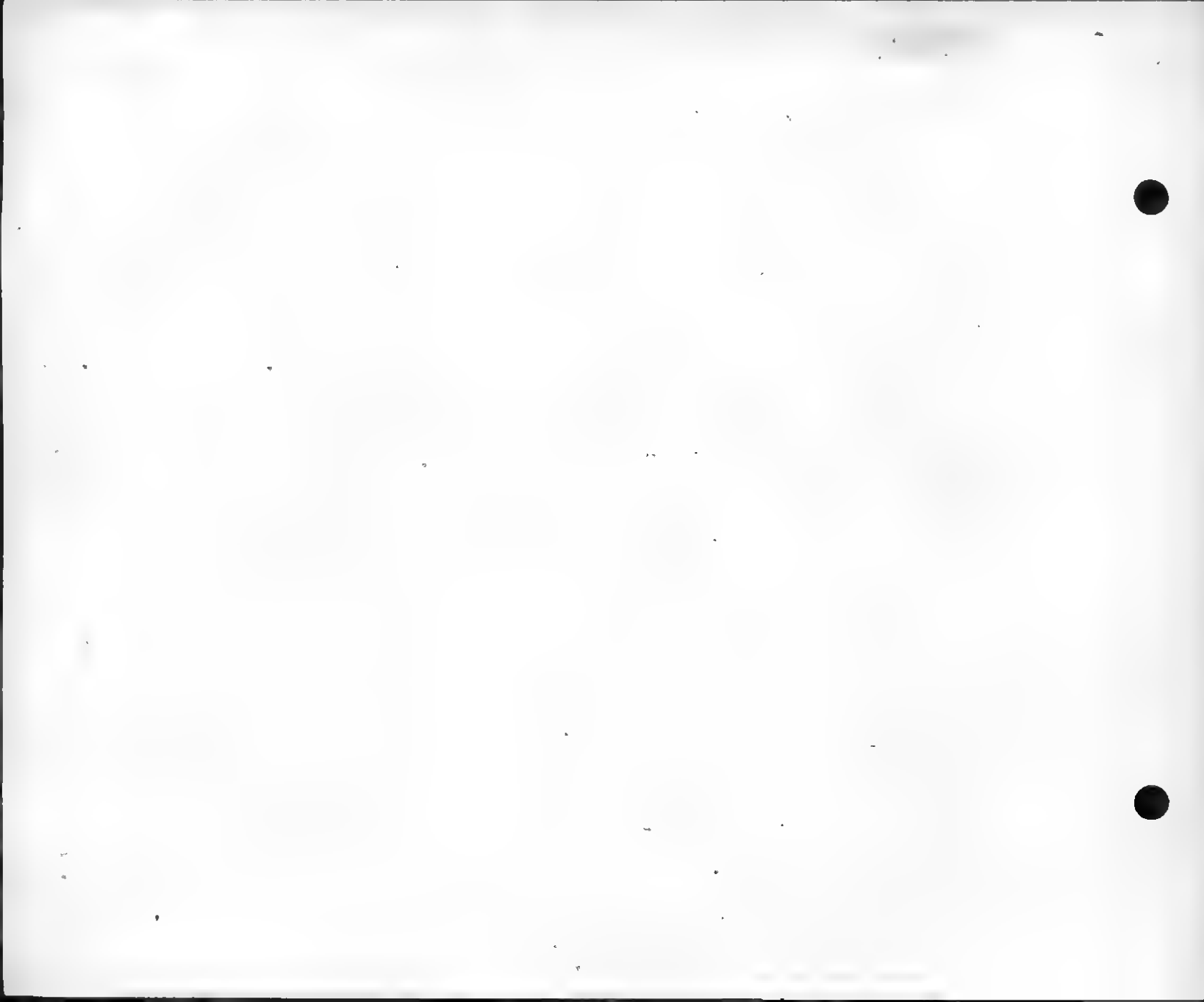
17325

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17324

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived) 1 institution 2 Residence before admission a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e STREET ADDRESS <u>5424 Mohican Rd</u>			
3 NAME OF DECEASED (Type or print) <u>William Nelson Oliver</u>				4 DATE OF DEATH <u>Dec-9-1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 13, 1900</u>	9 AGE (In years last birthday) <u>67</u> yrs	10 UNDER 1 YEAR Months Days		11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Insurance Agent</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13 FATHER'S NAME <u>Joseph A. Oliver</u>				14 MOTHER'S MAIDEN NAME <u>Anna Kinsinger</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOCIAL SECURITY NO <u>578-44-5350</u>		17 INFORMANT <u>Wife</u> <u>Linda P. Oliver</u>		Address <u>Same as Item 2.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Smoke inhalation & Carbon Monoxide Poisoning</u> DUE TO (c) <u>Conflagration (Fire in home)</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>House caught fire while asleep</u>				
20c. TIME OF INJURY Month Day Year <u>12:45 PM Dec-9-1967</u>			20d. NATURE OF INJURY While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Glen Echo Heights, Montgomery Md</u>
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/9/67</u> Address (Street city town or county) <u>Bethesda, Md.</u>				
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>			22. DATE SIGNED				
23a BURIAL CREMATION REMOVAL (Specify) <u>Cremation 12-13-67</u>		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory Suitland Pr, Geo Md</u>		23d LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</u>				25a REG. D BY REGISTRAR <u>DEC 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
25M 1/67

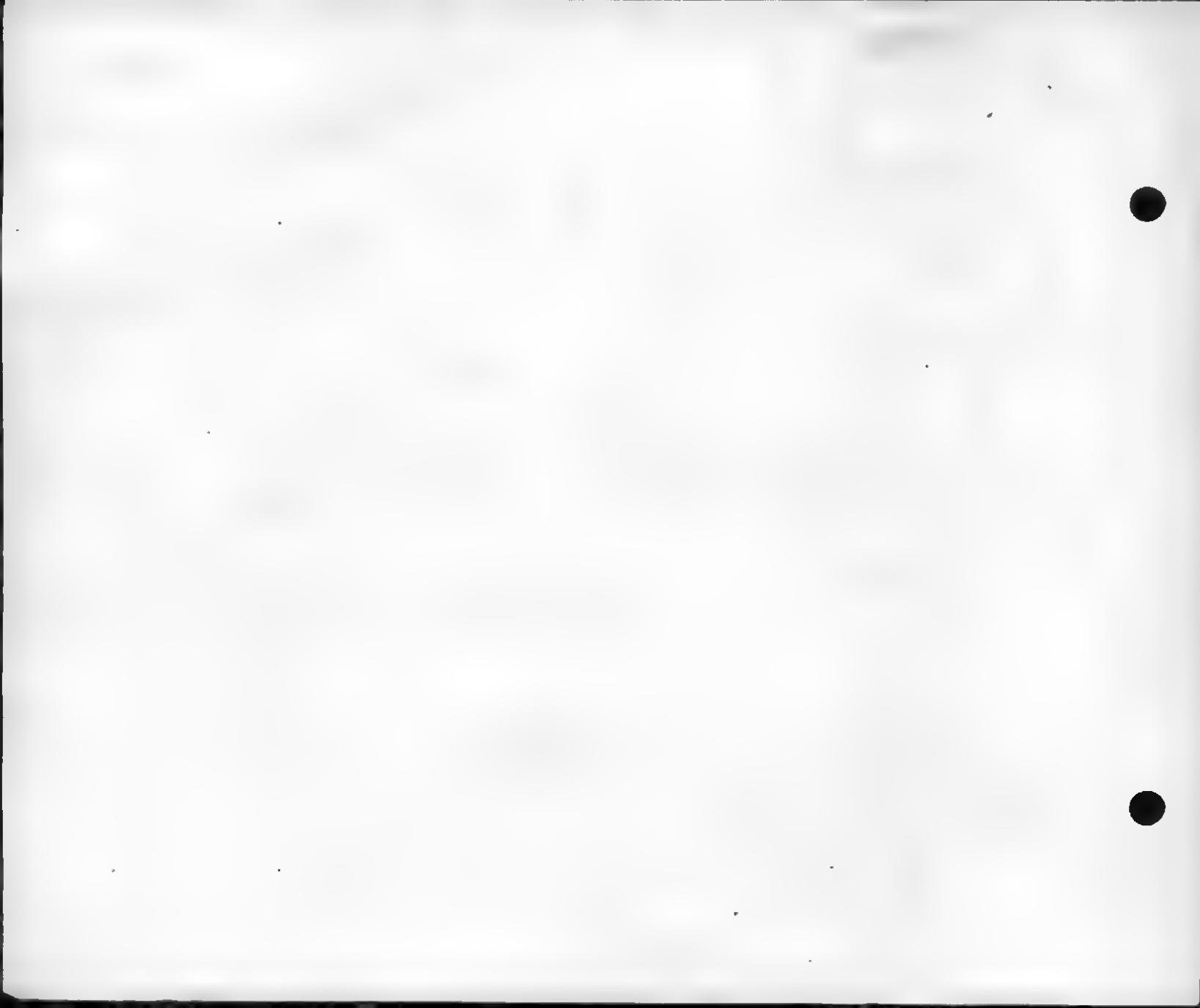
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1326

17325

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN TB <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>306 Reading Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert C.</u> Middle <u>ORAM</u> Last <u></u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 SEPT 1895</u>	
9. AGE (in years last birthday) <u>72</u> Yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Military</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>	
13. FATHER'S NAME <u>Information not available</u>				14. MOTHER'S MAIDEN NAME <u>Information not available</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Not known</u>				16. SOCIAL SECURITY NO. <u>Not known</u>		17. INFORMANT <u>306 Reading Ave.</u> <u>Leona Oram Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BILATERAL CONFLUENT LOBULAR PNEUMONITIS</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>13 NOV</u> , <u>1967</u> to <u>14 DEC</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>14 DEC</u> , <u>1967</u> , and that death occurred at <u>7:00 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>E. Perlin</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>16 DECEMBER 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. PERLIN, LCDR, MC, USN</u>				22d. ADDRESS <u>NAVAL HOSPITAL, BETHESDA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>1331 Montgomery Ave.</u> <u>Tyson & Wheeler, Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CLEARED WITH DR. REAR, B.B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

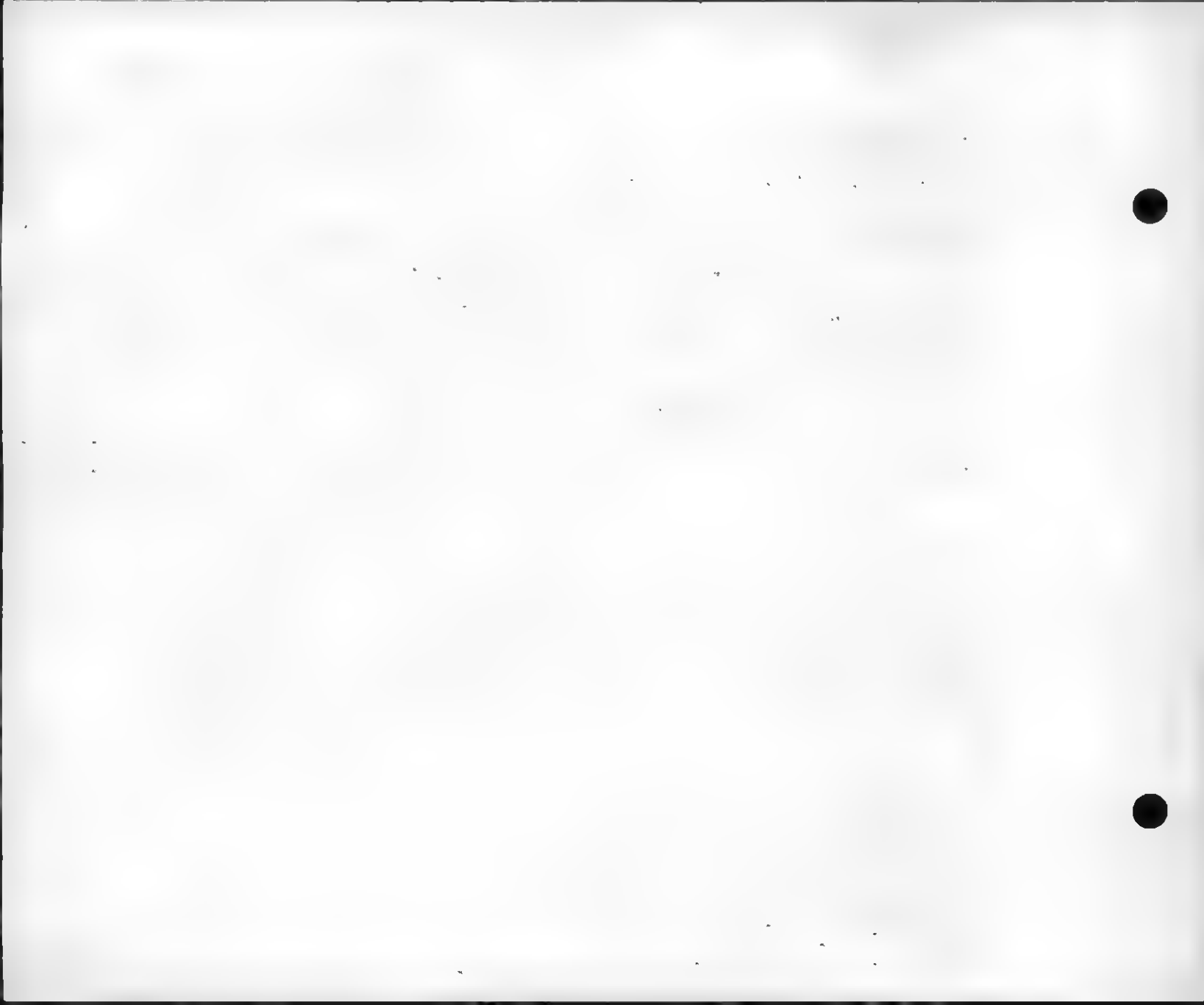
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7327

17326

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 8105 EASTERN AVE #314	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ARLEY OSWALT		4 DATE OF DEATH Month Day Year 12 - 26 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-1-86
9 AGE (In years last birthday) 81 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11 BIRTHPLACE (County & State, or foreign country) MISSISSIPPI		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE WOOD		14. MOTHER'S MAIDEN NAME SYBIL WHITE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-54-6661	
17 INFORMANT GRACE OSWALT - SAME		18 ADDRESS 8105 Eastern Ave., S.S.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion DUE TO Gen Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cornary Thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 17 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/6/50 , 19 50 , to 12/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 5/17/67 , 19 67 , and that death occurred at 12/26/67 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE H. T. Morse		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) H. T. Morse		22d. ADDRESS 3036 Carroll Ave Takoma Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify).	23b. DATE THEREOF Dec. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Lakewood Memorial Park	23d. LOCATION (City or Town) (County) (State) Jackson, Mississippi
24. FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Avenue Wanner E. Humphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17327

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heaton</u>				c LENGTH OF STAY IN 1b <u>36 mos.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>MORRIS - PARELMAN</u>				4 DATE OF DEATH <u>DEC. 24</u> 19 <u>67</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Cauc</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3/20/1882</u>	
9 AGE (In years last birthday) <u>85</u>		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessness</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>				13 FATHER'S NAME <u>Samuel Parcelman</u>			
14 MOTHER'S MAIDEN NAME <u>CECILE HARRIS</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16 SOCIAL SECURITY NO <u>UNKNOWN</u>				17 INFORMANT <u>SAMUEL PARELMAN</u> Address <u>1060Y BOCKNELL DR</u>			
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c))							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, Part I or Part II of Item B)			
20c TIME OF INJURY Month, Day, Year <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)				20g (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED <u>DEC. 24 1967</u>				DEPUTY MEDICAL EXAMINER <u>Heaton</u> (County) <u>Montgomery</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12/26/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. Sharon Cem</u>		23d LOCATION (City or town) (County) (State) <u>Reel Cou., Pa.</u>	
24 FUNERAL DIRECTOR <u>Salisbury Funeral Home</u> ADDRESS <u>4217-9 E. Lee</u>				25a REC'D BY REG. STRAR <u>DEC 27 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

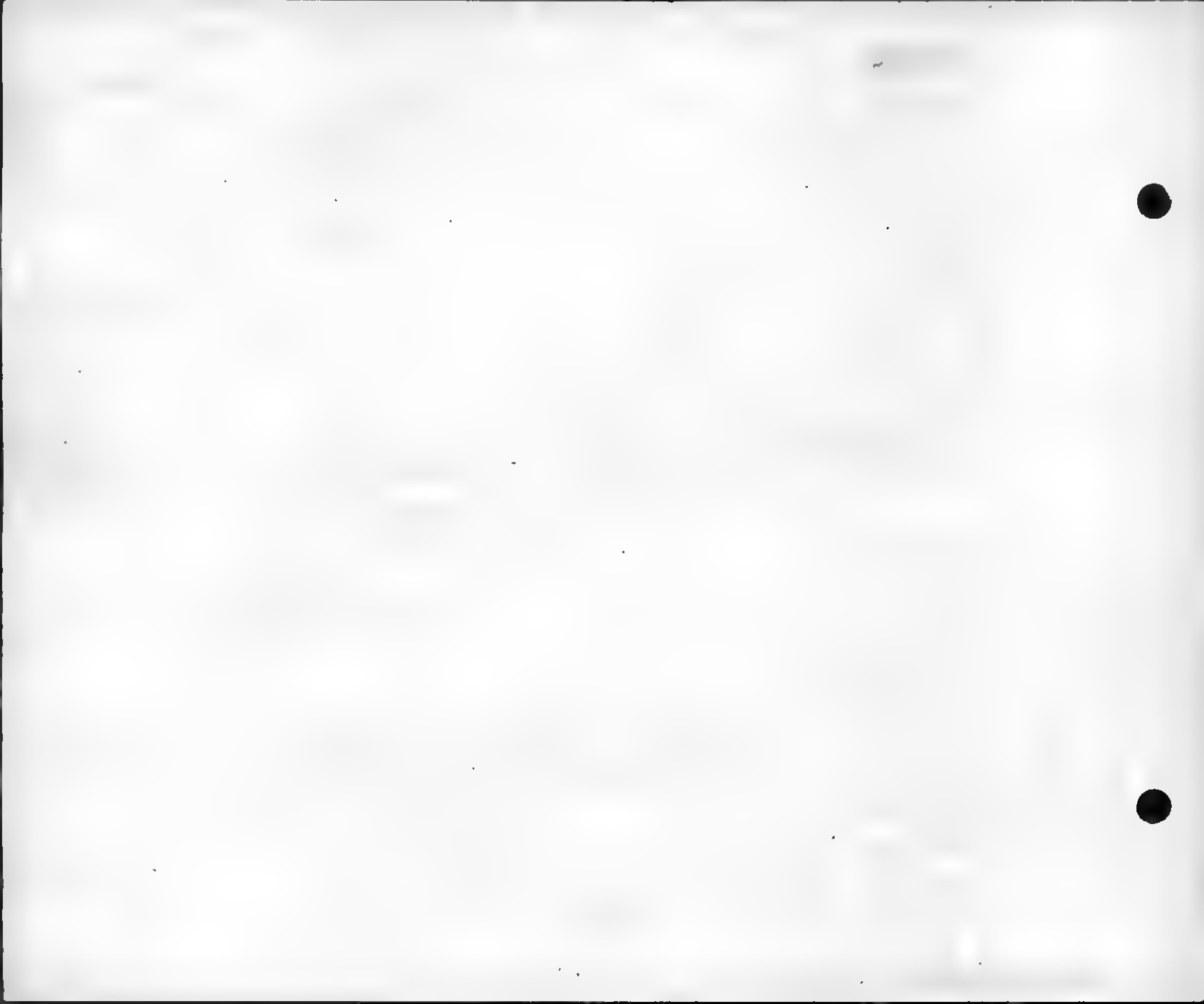
VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GRIFFITH CHASE NURS. & CONV. CENTER		e. STREET ADDRESS Washington, D. C. 4000 Mass. Ave., N. W.	
3. NAME OF DECEASED Elizabeth First ESTTY Middle Bobman Last PARIS		4. DATE OF DEATH Dec. 12 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/02
9. AGE (in years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Bobman		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 579-58-3043	
17. INFORMANT Robert Paris		Address Sil. Spr. Md. 900 Clintwood Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Cerebral Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- (c) -----		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1950 , 19 1950 , to Dec. 12, 1967 , that (I) (we) last saw the deceased alive on Dec. 11, 1967 , and that death occurred at 7:22 M, from causes and on the date stated above.			
22a. SIGNATURE Le Roy Robins		22b. DATE SIGNED 12-12-67	
22c. PHYSICIAN'S NAME (Type) Le ROY ROBINS		22d. ADDRESS 2480 16th St., N. E., Wash., D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/14/67	23c. NAME OF CEMETERY OR CREMATORY Roosevelt Cemetery	23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 18 1967	
ADDRESS 4217 9th St., N. E.		25b. REGISTRAR'S SIGNATURE William J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

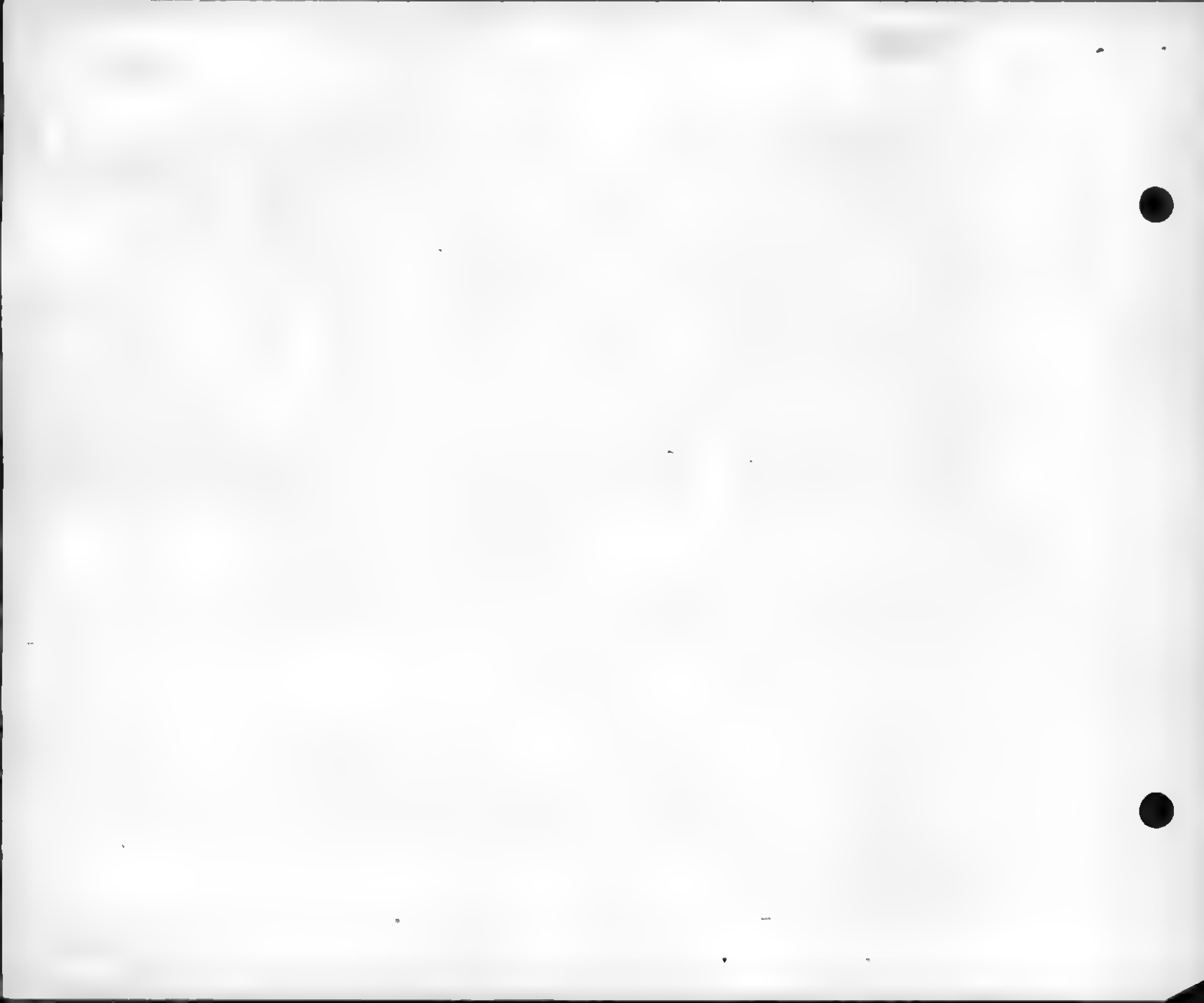
CERTIFICATE OF DEATH

17329

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#11 - Chase Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>Bethesda</u>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Patten</u> Last <u>Patten</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 18, 1919</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>13</u> Hours <u>48</u> Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) <u>plaster contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>	
11. FATHER'S NAME <u>Sidney Patten</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pennsylvania U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes Army</u>		14. MOTHER'S MAIDEN NAME <u>Bethesda</u>	
15. SOCIAL SECURITY NO. <u>191-18-0846</u>		16. INFORMANT <u>Wife - Elizabeth Patten</u>	
17. ADDRESS <u>Bethesda</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4201</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1967</u> to <u>Dec 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 29, 1967</u> , and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. L. S. Downman</u> M.D.		22b. DATE SIGNED <u>12/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. S. DOWNMAN</u>		22d. ADDRESS <u>13218 WILSON AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-5-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DAHAN</u> 5 1968	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. tut. an. Residence before admission) a. STATE <u>Dist. of Co.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>D.C.A.</u>		d. STREET ADDRESS <u>115 Wayne Pl. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tamela Lynn Perminter</u>		4. DATE OF DEATH Month Day Year <u>Dec. 22 1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Kennedy, Virginia</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel L. Perminter</u>		14. MOTHER'S MAIDEN NAME <u>Jorditha Browder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>same</u>		16. SOCIAL SECURITY NO. <u>same</u>	
17. INFORMANT <u>Jorditha Perminter</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>491X</u> DUE TO (b) <u>491X</u> DUE TO (c) <u>491X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/23/67</u>	
		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State) <u>BEAVER FALLS, PA.</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., 517 12th St. S.E., WASH. D.C.</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		DATE <u>DEC 29 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

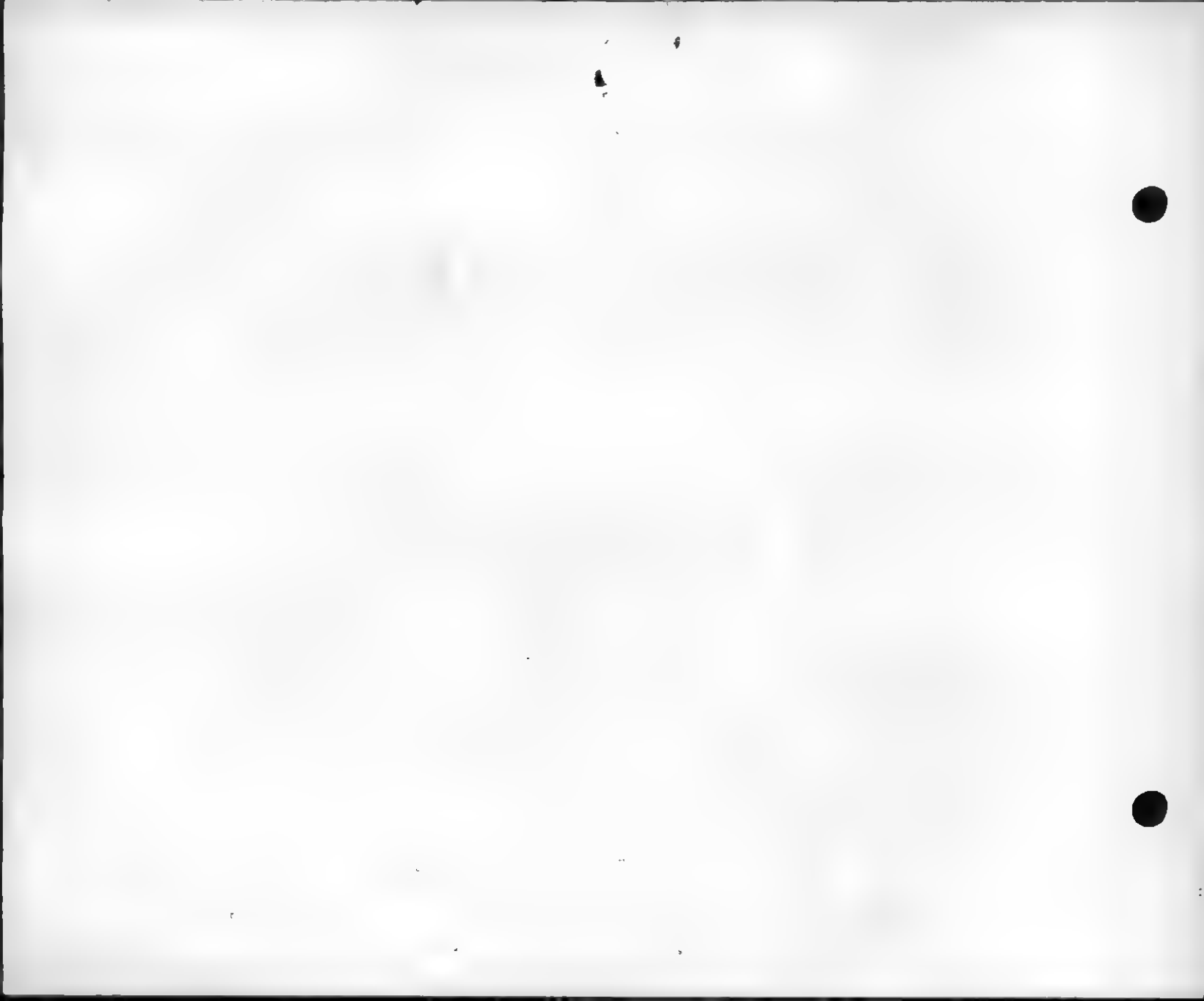
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17331

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>8811 Colesville Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Z</u> Last <u>Philpott</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/04</u>
9. AGE (in years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>H.E. ZERNER</u>		14. MOTHER'S MAIDEN NAME <u>MAY RISTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY NO <u>- - -</u>	
17. INFORMANT <u>HAROLD M. PHILPOTT-SEE ITEM #2.</u>		Address <u>- - -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphatic leukemia</u> 2001 DUE TO (b) <u>Lymphosarcoma</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>15 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>12/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>12/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Rd., Sil. Spr., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>12-19-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Park Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>New Castle, Pa.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 W. Ash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

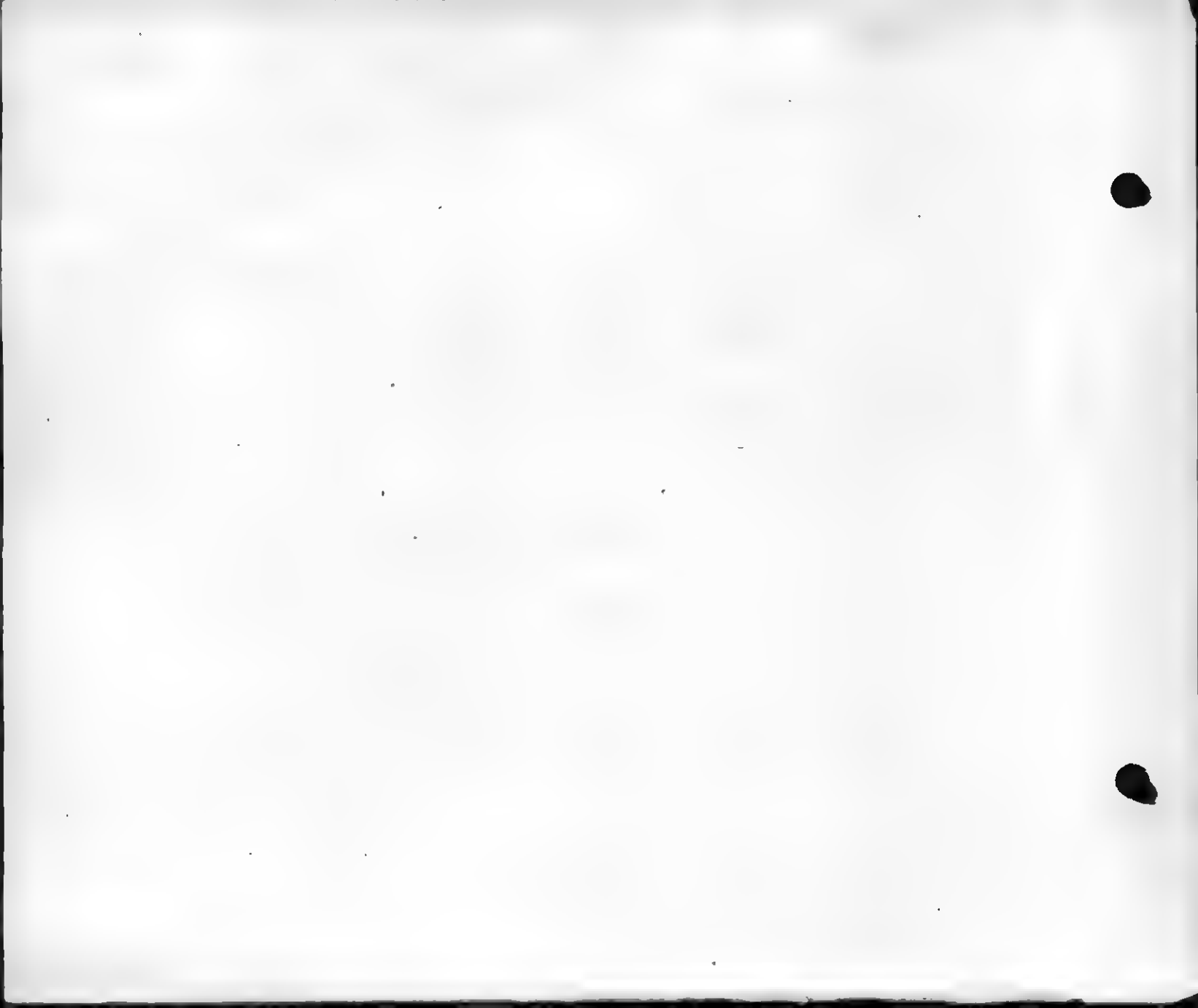


CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>Chevy Chase</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>3732 Manor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>R.</u> Last <u>Pitzer</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-78</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Rixey</u>		14. MOTHER'S MAIDEN NAME <u>Mary F. Wise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>MISS FRANKIE R. KEYSER-NIECE-ADELPHI, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2</u> hour <u>20</u> yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>65</u> , to <u>12/5</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>67</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John D. Griswold</u>		ADDRESS (Street, city or town, state) <u>4830 V Street, N. W.</u>	
PHYSICIAN'S NAME (Type) <u>John D. Griswold, M. D.</u>		DATE <u>12-5-67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12-7-1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Culpepper, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W., Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

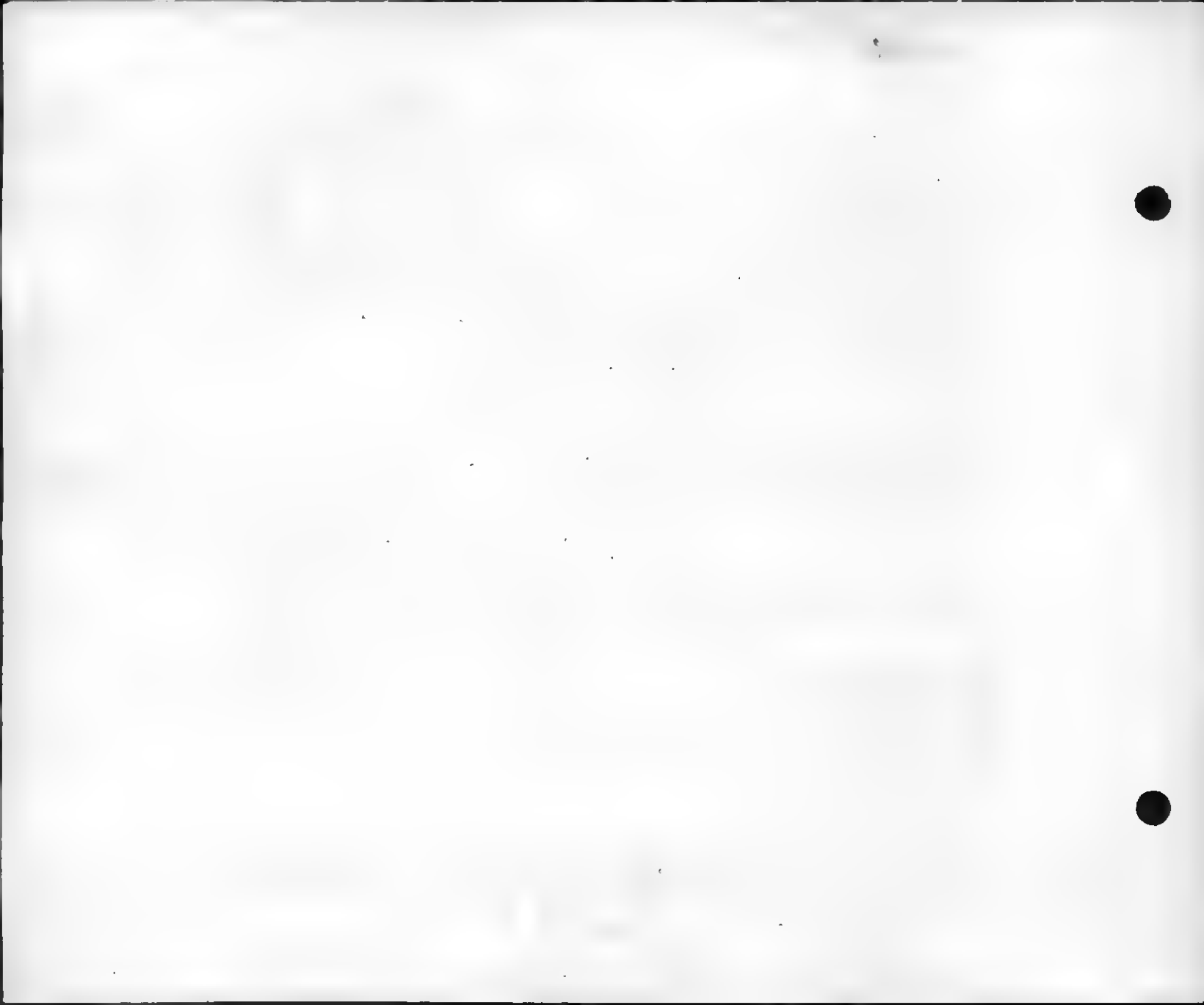
MARYLAND STATE DEPARTMENT OF HEALTH

17333 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6017 Neilwood Drive</u>				d. STREET ADDRESS <u>6017 Neilwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PLATT</u> Last <u>PLATT</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1890</u>		9. AGE (in years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Zalman Landow</u>				14. MOTHER'S MAIDEN NAME <u>Mollie ? ? ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>169-16-3259 D</u>		17. INFORMANT <u>Nathan Platt</u> Address <u>9332 Harvey Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis - Becke</u> DUE TO <u>Ext. Hypertensive Heart Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> , 19 <u>67</u> , to <u>12-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> 19 <u>67</u> , and that death occurred at <u>6</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Isidore Shulman</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12-9-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Isidore Shulman, M. D.</u>				22d. ADDRESS <u>915 19th Street N. W. Washington, D. C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church Va.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

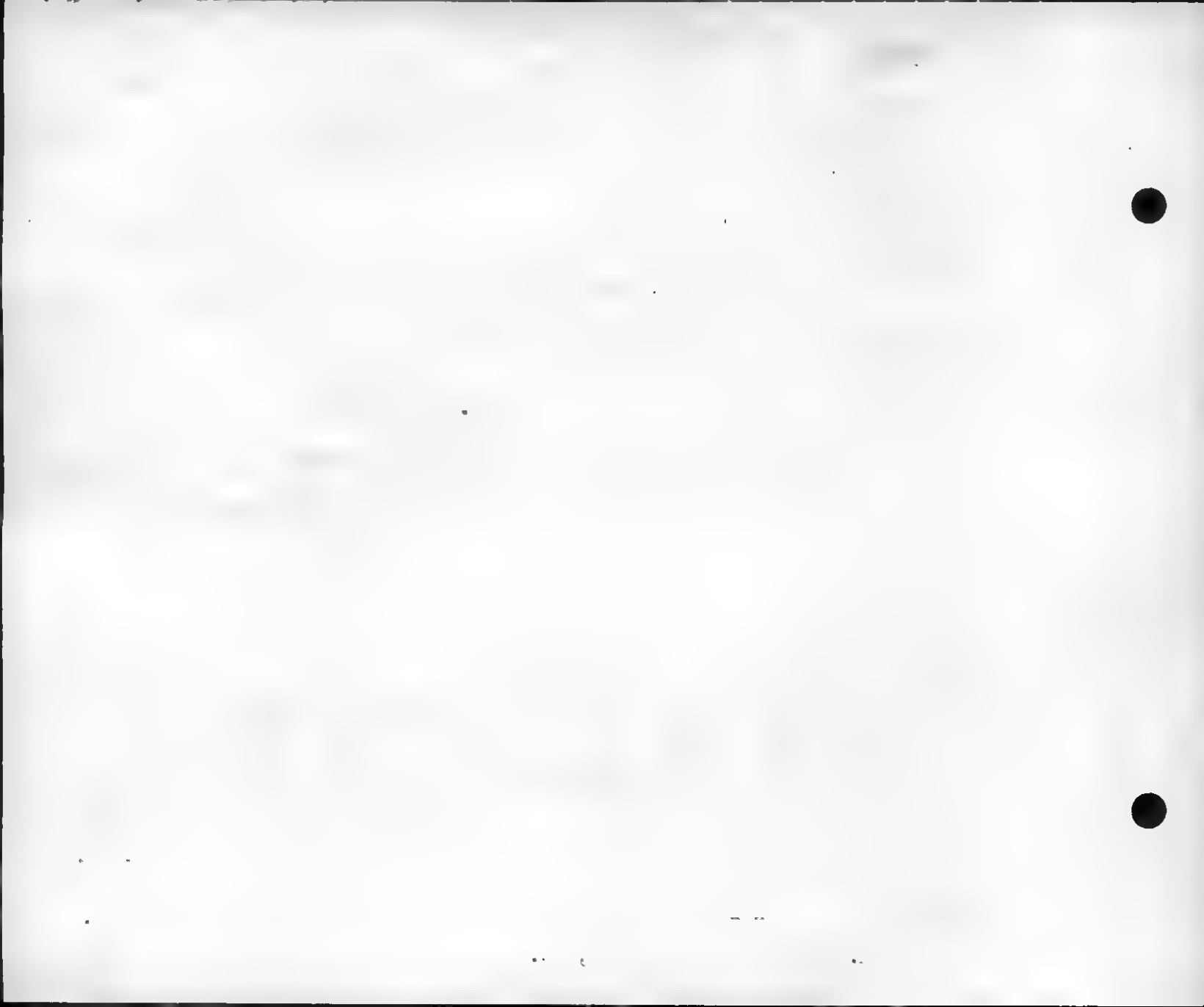
CERTIFICATE OF DEATH

17334

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 14 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYTONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LAMAR Last PLUMMER				4. DATE OF DEATH Month 12 Day 6 Year 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-92		9 AGE (In years lost birthday) yrs 75	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HOWARD A. PLUMMER				14. MOTHER'S MAIDEN NAME R. IDA CRAWFORD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 218-10 8492		17. INFORMANT MEDICAL RECORD DEPT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident - basilar artery DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia, Diabetes mellitus, Chronic lymphatic leukemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour: a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1965 , to Dec. 6, 1967 , that (I) (we) last saw the deceased alive on Dec. 6, 1967 , and that death occurred at 3:05 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Frederick Moomau M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-6-67	
22c. PHYSICIAN'S NAME (Type) FREDERICK MOOMAU, M. D.				22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-67	23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or town) (County) (State) Laytonsville Mont Md.		
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.				25a. REC'D BY REGISTRAR DEC 8 1967		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-21 Film 396

1-15-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

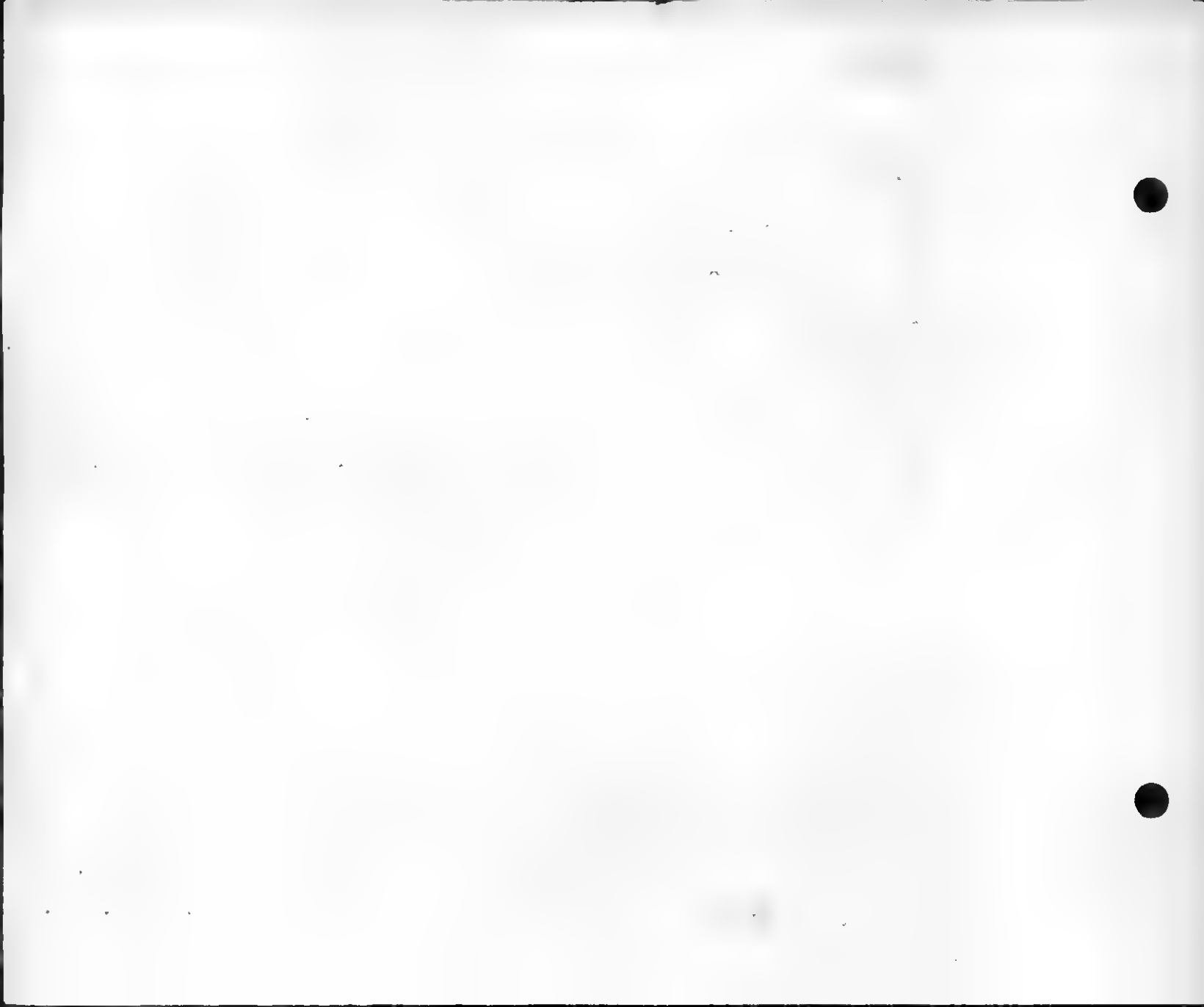
17335

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17335

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
c LENGTH OF STAY IN IB 23 hrs.		d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital	
3 NAME OF DECEASED (Type or print) First Middle Last George Alexander Powell		4 DATE OF DEATH Month Day Year 12 9 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 6/11/08
9 AGE (In years lost birthday) 59 yrs		10 IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher		10b. KIND OF BUSINESS OR INDUSTRY Hospital 7	
11 BIRTHPLACE (State or foreign country) Sandy Spring Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. Chase		14 MOTHER'S MAIDEN NAME Imma Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17 INFORMANT Brother/Milton Powell/Sandy Spring Md		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Shock and acute diffuse purulent 8/16.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) peritonitis due to traumatic rupture DUE TO (c) of ileum		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Deceased, driver, collided head-on with another auto.			
20a. TIME OF INJURY Month, Day Year 4:48 p.m. 12-8 19 67		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased, driver, collided head-on with another auto.	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Street	
20e. CITY OR TOWN Rockville		20f. COUNTY Montg.	
20g. STATE Md.		20h. CITY OR TOWN Rockville	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED DEC. 10, 1967		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24. ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		25. ADDRESS Rockville, Maryland	
26a. BURIAL CREMATION REMOVAL (Specify) Burial		26b. DATE OF BURIAL 12/13/67	
26c. NAME OF CEMETERY OR REMATORY Ash Memorial Cemetery		26d. LOCATION (City or Town) (County) (State) Sandy Spring, Montg., Md.	
27. REGISTRAR'S SIGNATURE Robert L. Swarden		28. DATE DEC 15 1967	

VR A15ME (5)
6M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

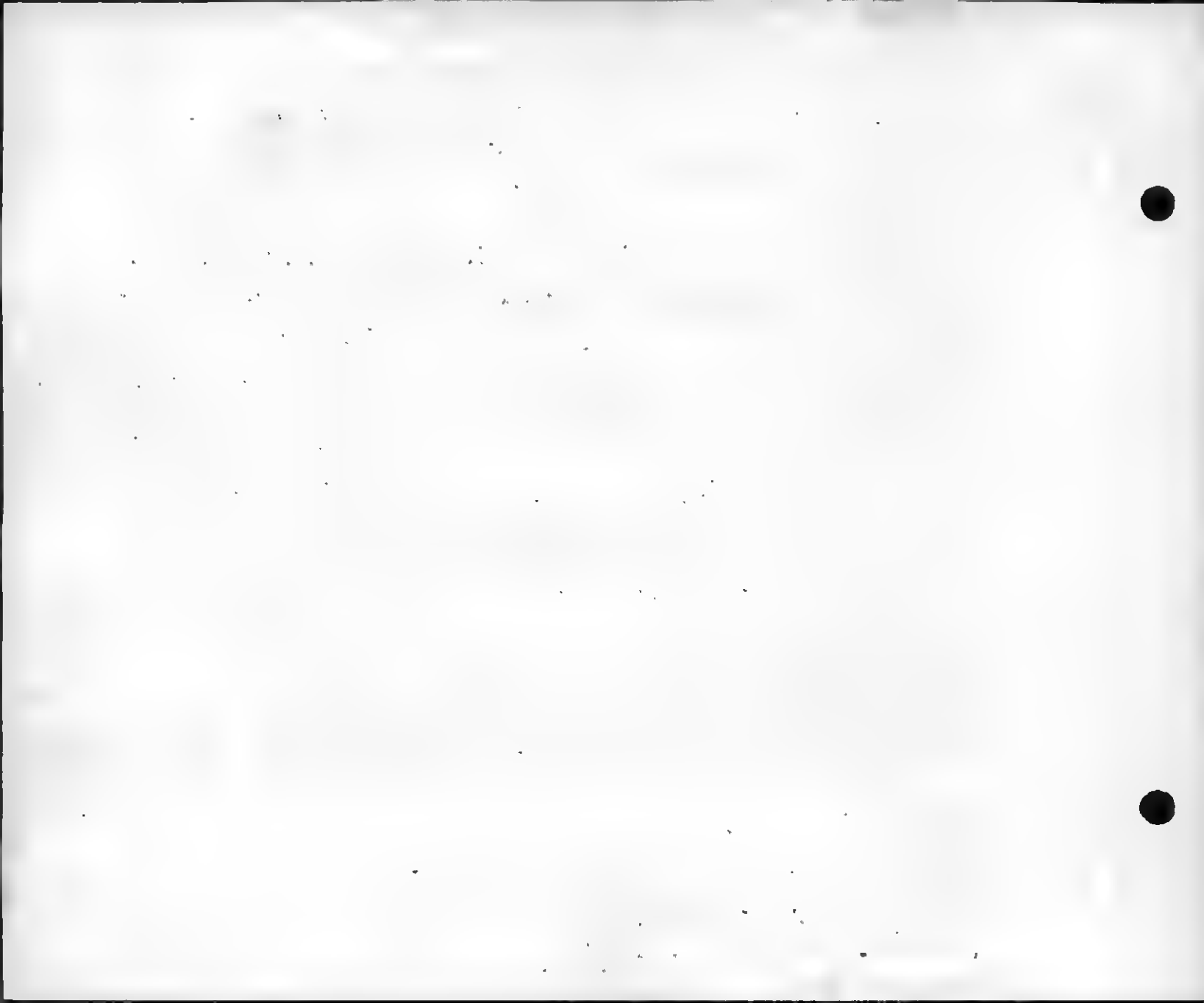
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>C</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delbarton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>Route #1, Box 191C</u>	
3 NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>(NMN)</u> Last <u>Preece, Jr.</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>19 67</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1957</u> <u>22 September</u>
9 AGE (In years last birthday) yrs <u>10</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harold Preece, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Peggy Sue Runyon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration, Pneumonia</u> DUE TO (b) <u>Gastrointestinal Hemorrhage</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u>			INTERVA. BETWEEN ONSET AND DEATH <u>48 Hours</u> <u>24 hours</u> <u>40 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Miliary tuberculosis - inactive.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>27 November, 19 67</u> , to <u>26 Dec.</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>26 December</u> , 19 <u>67</u> , and that death occurred at <u>5:45M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Creech</u>		22b. DATE SIGNED <u>1967</u> <u>27 December</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Creech, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Removed</u>	23b. DATE THEREOF <u>12-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <u>Delbarton W Va.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc</u>		25a. REC'D BY REGISTRAR <u>1400 Chapin St NW Wash, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JAN 2 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 13a, b, c, & e Film G396											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Logan						Presler		December 20 1967		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Feb. 8, 1882		85 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Ohio						Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Resmor Saw Glasgow Lane				Lawyer- U.S. Gov't.		U.S. Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TS?		13e. STREET AND NUMBER			
D.C. Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3471 Groveton Lane NW			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Hiram						Presler		Mathilde		Herbert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
		579-62-6656-T		Cpt. Irving Presler/ 10861 Springknoll Dr. Potomac, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Severe Generalized Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Diabetic Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 1943, to Dec. 20, 1967, that (I) (we) last saw the deceased alive on 12-20-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
PP Andrews M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 12-20-67											
22d. PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D. 22e. ADDRESS WASHINGTON D.C.											
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12-22-1967		Rock Creek Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR											
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C. 25a. REC'D BY REGISTRAR DATE DEC 28 1967 25b. REGISTRAR'S SIGNATURE [Signature]											



VR A15 (4)
25M 1/67

1. PLACE OF BIRTH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>1 day</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> d. STREET ADDRESS <i>10812 Hobson St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Albert E.</i> Middle <i>Price</i> Last <i>Price</i>		4. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1967</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/6/97</i>
9. AGE (In years last birthday) <i>70</i> yrs		IF UNDER 1 YEAR: Months <i></i> Days <i></i>	IF UNDER 24 HRS: Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief Clerk, Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- -</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Price</i>		14. MOTHER'S M maiden name <i>Hanna Elliott</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, not known) (If yes, give war or dates of service) <i>US Army</i>		16. SOCIAL SECURITY NO <i>578 10 1402 A</i>	
17. INFORMANT <i>Same as above</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 yrs</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. <i>19</i> p.m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/1</i> , 19 <i>63</i> , to <i>12/27</i> , 19 <i>67</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>12/27</i> , 19 <i>67</i> , and that death occurred at <i>5pm</i> , from causes and on the date stated above			
22a. SIGNATURE <i>John E. Everett</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JOHN E. EVERETT</i>		22d. ADDRESS <i>Kensington, Md. 9400 Conn. Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>12-30-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to a burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17339

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IB <u>72 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>R.D. #2</u>	
3 NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Andrew</u> Last <u>Przemyski, Jr.</u>		4 DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 December 1948</u>
9. AGE (In years last birthday) <u>18 yrs</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>England</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Richard A. Przemyski, Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Eva Lada</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>183-40-8572</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> <u>2073</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Septicemia with renal and perisplenic abscesses</u> DUE TO (c) <u>Acute myelogenous leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 weeks</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral edema (24 hours)</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 22, 1967</u> to <u>Dec. 3, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 3, 1967</u> , and that death occurred at <u>10:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David L. Lilien</u>		22b. DATE SIGNED <u>4 December 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>David L. Lilien, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Downingtown, Chester, Pa.</u>
24. FUNERAL DIRECTOR <u>Ralph W. Balston</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
ADDRESS <u>107 W. Lancaster Ave. Downingtown, Pa. 19335</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



12-28-67 ams

7341

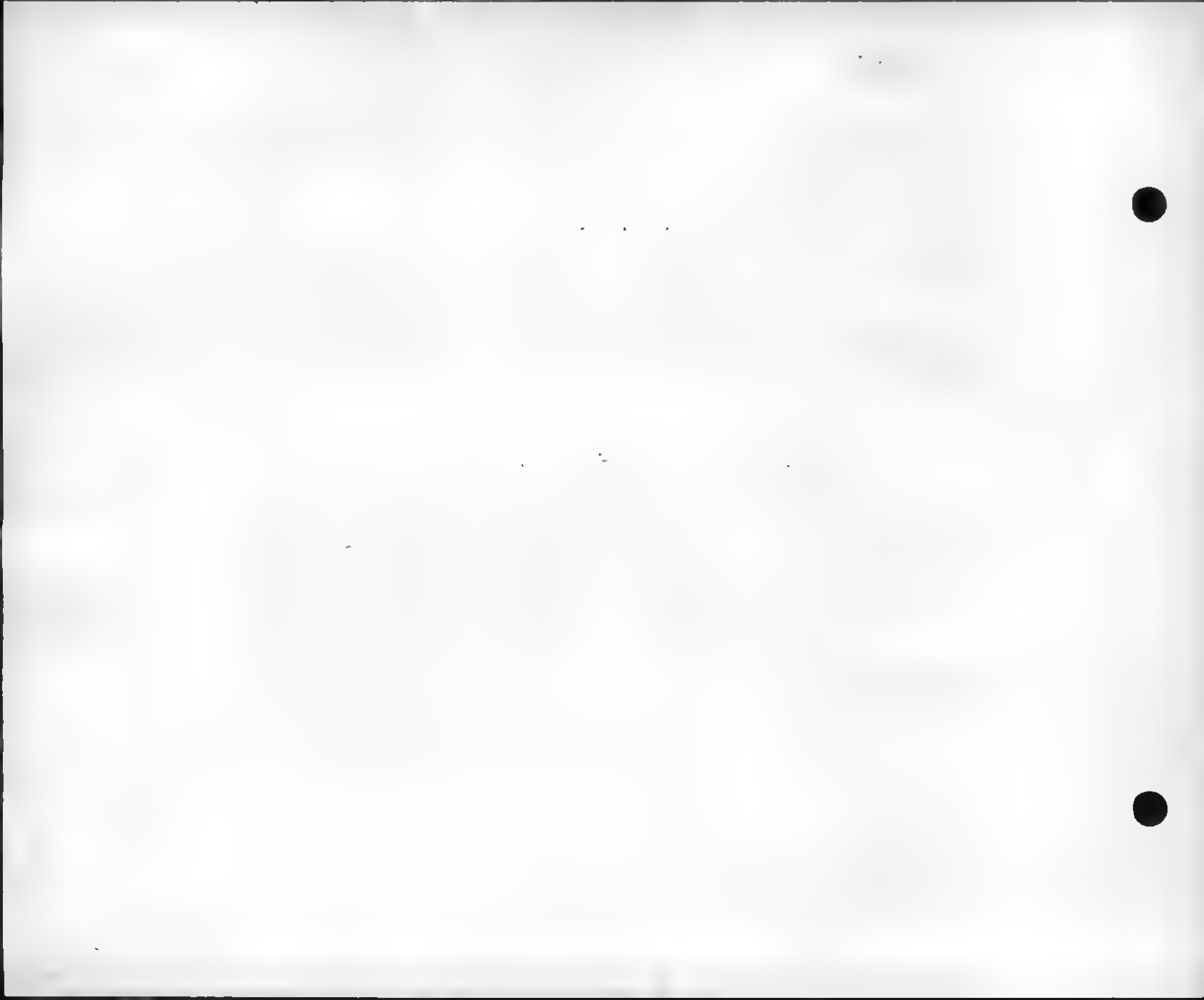
CERTIFICATE OF DEATH

17340

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center (N. I. H.)</u>				d. STREET ADDRESS <u>630 E. 93rd Street</u>			
3 NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>(NMN)</u> Last <u>Rappel</u>				4 DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 November 1912</u>	9 AGE (in years last birthday) <u>55 yrs</u>	FINDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rappel</u>				14. MOTHER'S MAIDEN NAME <u>Ida Meyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1943-45</u>		16. SOCIAL SECURITY NO. <u>116-07-7878</u>		17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> <u>4211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Calcific Aortic Stenosis, Post-Operative Aortic Valve Replacement</u> DUE TO (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>20</u> (this hospital) attended the deceased from <u>19 November 1967</u> to <u>1 December 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 December 1967</u> , and that death occurred at <u>2:15 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>James C. A. Fuchs</u>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James C. A. Fuchs, M. D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Mt. Carmel Cemetery Brooklyn New York</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Bernard Danzansky And Sons</u>				ADDRESS <u>3501 14th St. NW Wash. D.C. 20010</u>		25a. REC'D BY REG. STR. DATE <u>DEC 4 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Medical Examiner Dr. Belden Rapp has been notified concerning this death and he authorizes me to sign this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1342
1341

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>7 years</u>		d. STREET ADDRESS <u>1712 Alberti Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1712 Alberti Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Rausch</u> Last <u>Rausch</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1875</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Podlesak</u>		14. MOTHER'S MAIDEN NAME <u>Anna Cesal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-05-5666</u>	
17. INFORMANT <u>Frank C. Rousch</u>		Address <u>1712 Alberti Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebro-sclerosis</u> Undetermined DUE TO (c) <u>Generalized Arterio-sclerosis</u> Undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1966</u> to <u>Dec 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> 19 <u>67</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u>		22b. DATE SIGNED <u>Dec 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22d. ADDRESS <u>16620 Georgia Ave Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Dec. 20, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Emblem Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elmhurst Illinois</u>	
24. FUNERAL DIRECTOR <u>Clark & Elison</u>		25a. REC'D BY REGISTRAR <u>26 DEC 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Humphrey, Inc. Silver Spring, Md.</u>		25c. REGISTRAR'S SIGNATURE <u>Charles E. Humphrey, Inc. Silver Spring, Md.</u>	



856-67 1

1043

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

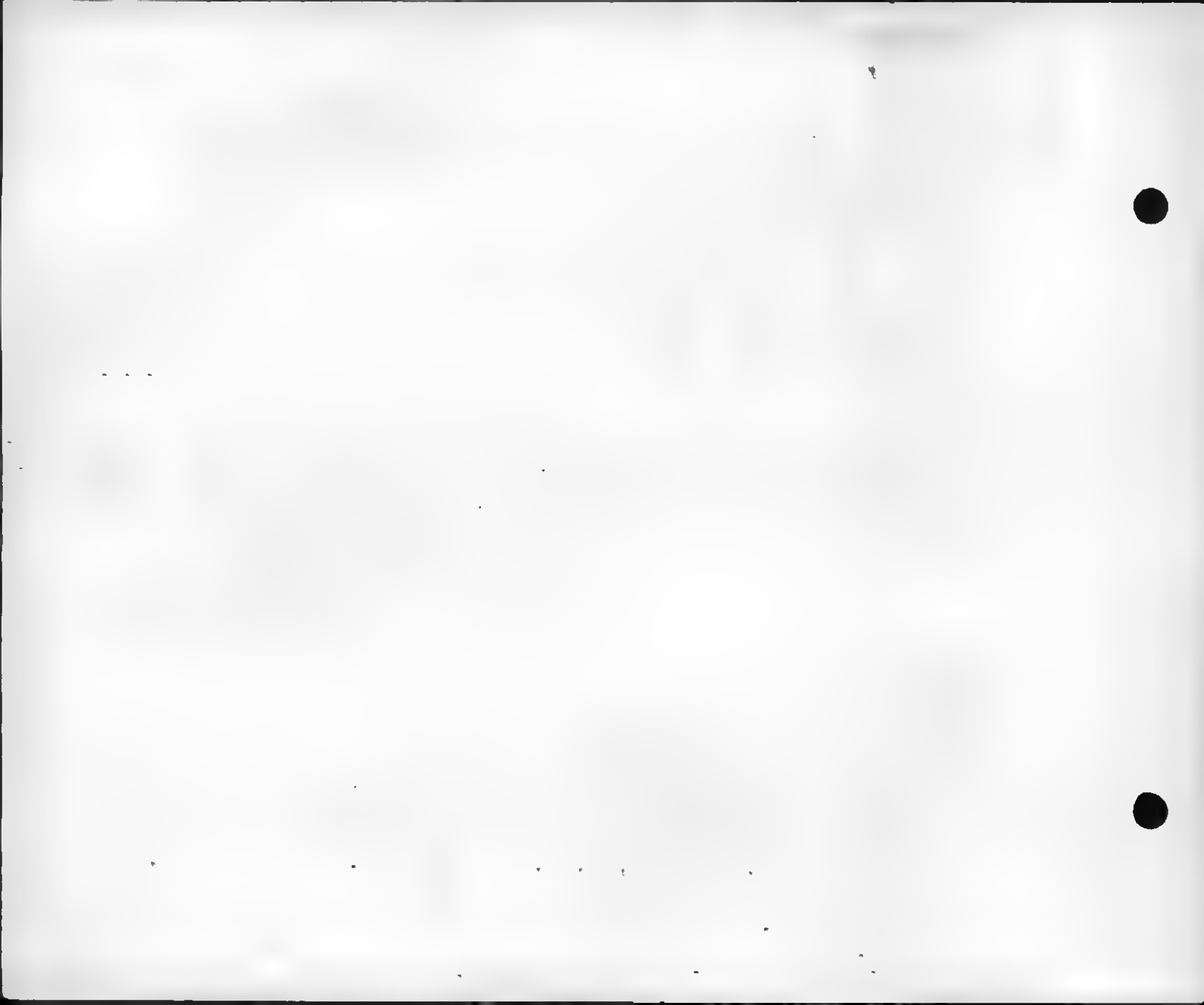
CERTIFICATE OF DEATH

17342

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Penn Shop Road Route 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa</u>		d. STREET ADDRESS <u>1000 Penn Shop Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Reece</u> Last <u>Reece</u>		4 DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-17-01</u>
9. AGE (in years last birthday) <u>26 Yrs</u>		10. FINDER 1 YEAR Months <u>12</u> Days <u>29</u> Hours <u>11</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Newark, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>195-07-7094</u>	
17. INFORMANT <u>John Stroman, House</u>		Address <u>5729 Windle Rd. Mechanicsburg, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive gastrointestinal bleeding</u> DUE TO (b) <u>Recurrent CA of stomach with liver nodes</u> DUE TO (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (th s hospital) attended the deceased from <u>Nov 30</u> , 19 <u>67</u> , to <u>12 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 28</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> P. M., from causes and on the date stated above.			
22a. SIGNATURE <u>Benne G. Bendler</u>		22b. DATE SIGNED <u>12-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Benne G. Bendler, M. D.</u>		22d. ADDRESS <u>10820 Ga. Ave Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>Dec. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>
24. FUNERAL DIRECTOR <u>Clark & Co.</u>		25a. JAN 8 1968 DATE	

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

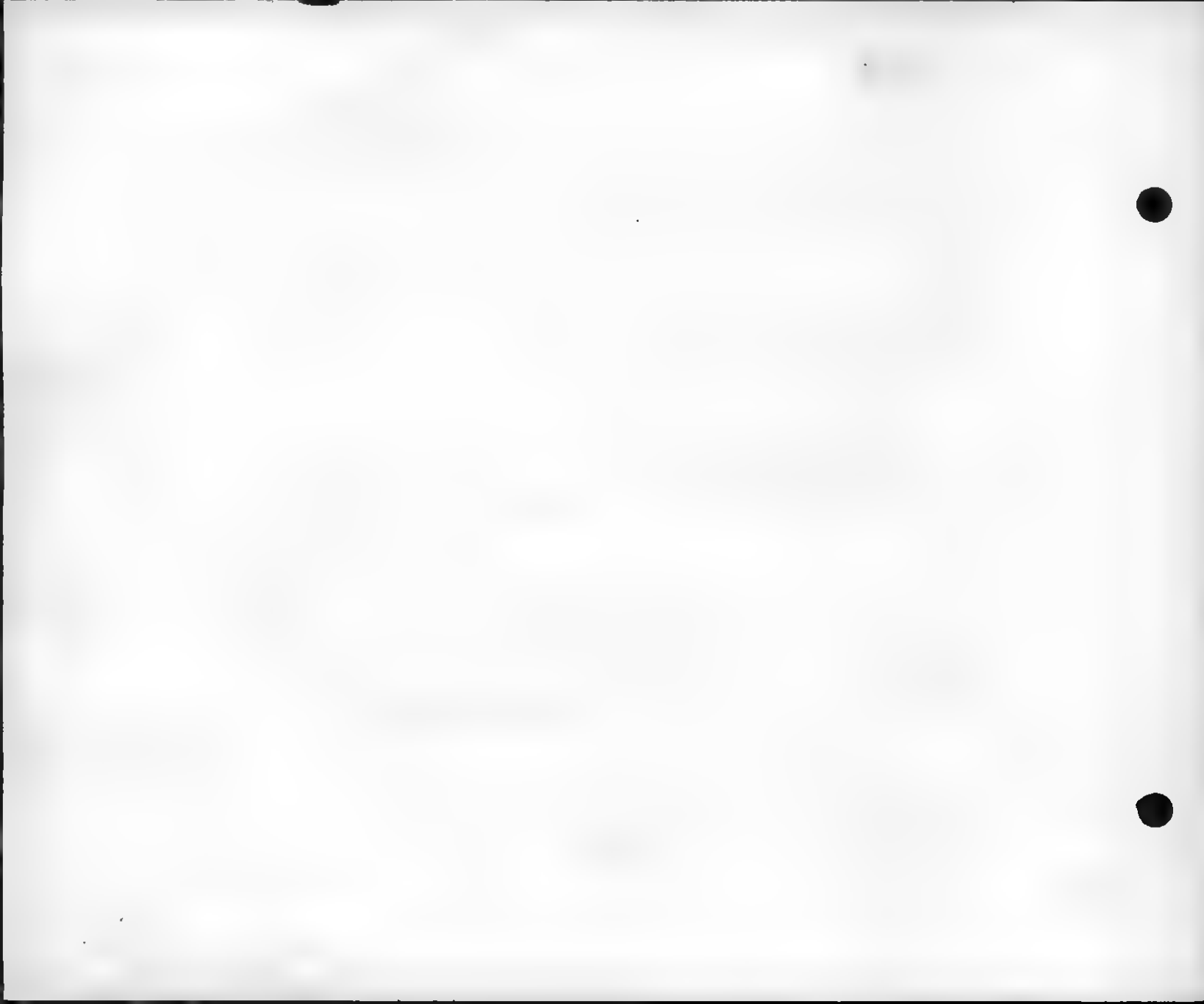
17344

CERTIFICATE OF DEATH

17343

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>12824 Fern Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Edna Grace Reed</u>		4. DATE OF DEATH <u>December 28 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24 - 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Registered Nurse</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland -</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lepore</u>		14. MOTHER'S MABLE NAME <u>Mollie Priscilla White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-9743</u>	
17. INFORMANT <u>Mrs. Annell</u> Address <u>12824 Fern Drive, Fort Belvoir, Va.</u> (daughters)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> , 19 <u>67</u> , to <u>12/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>67</u> , and that death occurred at <u>11:21 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Daddario</u> M.D.		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>		22d. ADDRESS <u>5413 CEDAR LANE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/2/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Herndon Fairfax Va.</u>
24. FUNERAL DIRECTOR <u>William C. Hiltz, Pennsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

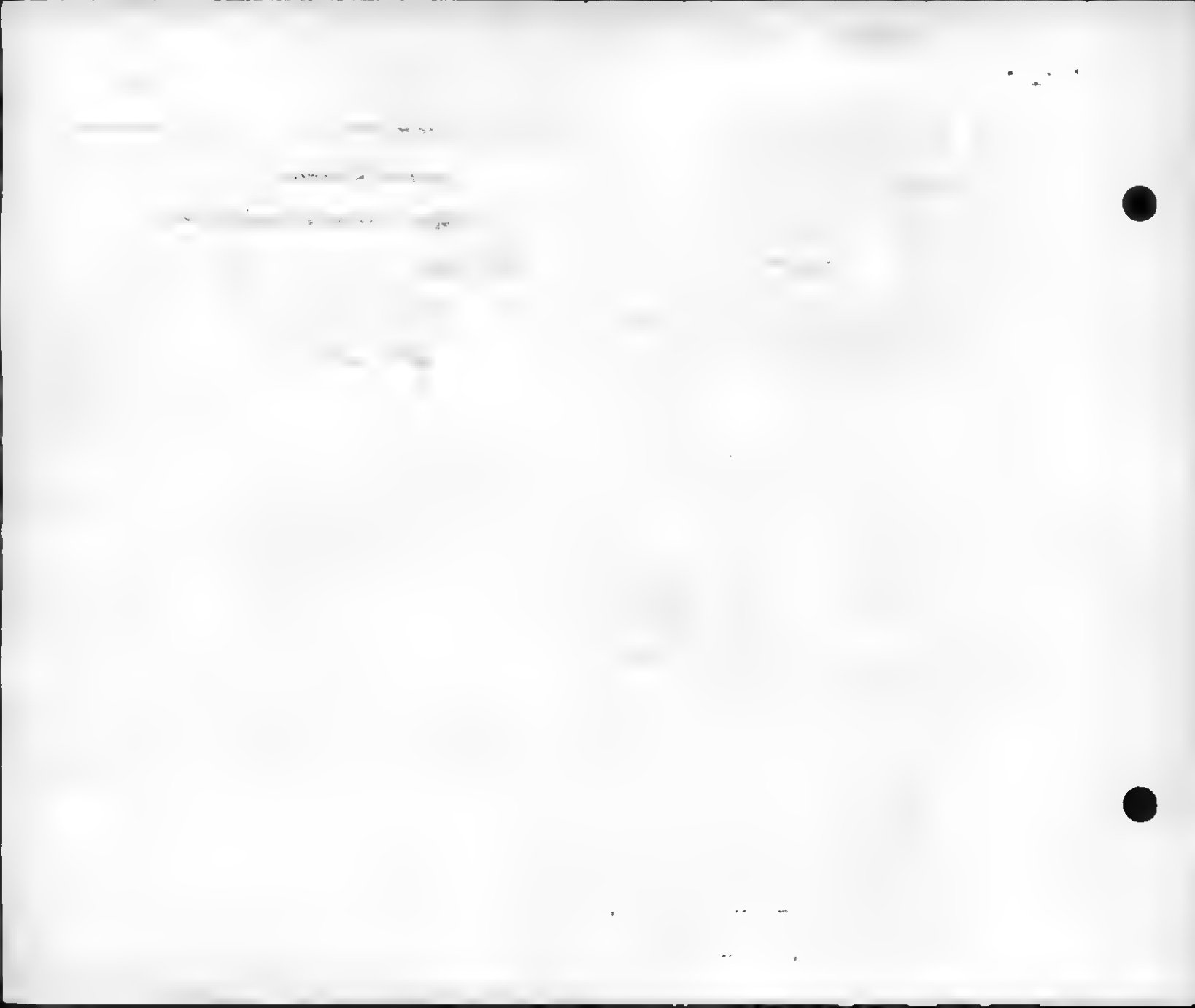
VR A15 (4)
25M 1/67

1045 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17345

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASH DC b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING WASH. DC	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 3609 Nichols Ave SE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) RALPH A REINHART SR		4 DATE OF DEATH 12 25 1967	
5 SEX male	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-95
9 AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd		10b. KIND OF BUSINESS OR INDUSTRY Auto Service	
11. BIRTHPLACE (County & State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawrence J. Reinhart		14. MOTHER'S MAIDEN NAME Stella E. Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WWI 6-5-17-4-22-19		16. SOCIAL SECURITY NO 65-17-4-22-19	
17. INFORMANT Ralph A. Reinhart Jr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Subdural Hemorrhage 200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Dissecting		INTERVAL BETWEEN ONSET AND DEATH 1 day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unimportant		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 to Dec 25, 1967 that (I) (we) last saw the deceased alive on Dec 25 1967 and that death occurred at 11:45 PM from causes and on the date stated above.			
22a. SIGNATURE John J. Curry		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY		22d. ADDRESS 70620 Georgia Ave SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or town) (County) (State) Washington DC	
24. FUNERAL DIRECTOR Simmons Bros		25a. REC'D BY REGISTRAR DEC 28 1967	
ADDRESS Wash DC		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

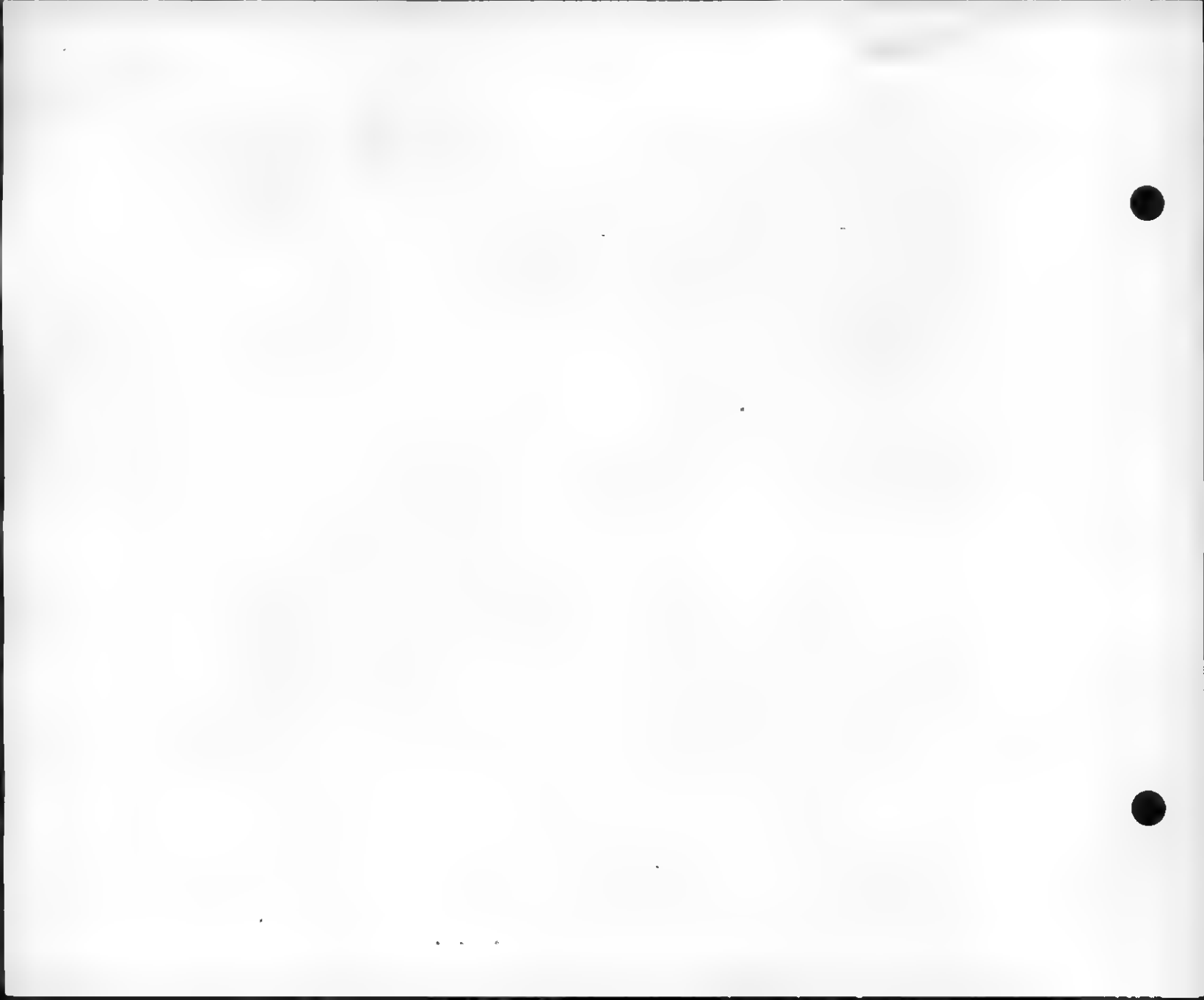
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
248

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11344

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VIRGINIA b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c LENGTH OF STAY in lb 4 mos. 9 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA-SILVER SPRING NURSING HOME		e STREET ADDRESS 3430 PICKETT RD.	
3 NAME OF DECEASED (Type or print) First NAN Middle DEBNER Last DEBNER		4 DATE OF DEATH Month DEC Day 5 Year 1967	
5 SEX FE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-9-82
9 AGE (In years last birthday) 85 8/27 yrs		IF UNDER 1 YEAR Months 8 Days 27 Hours 0 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) ILLINOIS		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME William R. Taylor		14 MOTHER'S MAIDEN NAME Anna Day	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16 SOCIAL SECURITY NO 375-14-6281A	
17 INFORMANT PATIENT'S CHART		Address 8700 JONES MILL RD CHEVY CHASE, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO SSIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 15 MIN 5 yrs 10 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 3/67 , 19 to 12/5/67 , that (I) (we) last saw the deceased alive on 10/25/67 , 19, and that death occurred at 6:00 PM , from causes and on the date stated above.			
22a SIGNATURE Henry C. Seruoggs MD		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) HENRY C. SERUOGGS MD		22d ADDRESS 5413 Cedar Lane Bethesda Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF 12/7/67	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State) Nokomis, Ill.
24 FUNERAL DIRECTOR Joseph J. Lewis's Sons Inc		ADDRESS Wash., D.C.	25a REC'D BY REGISTRAR DEC 11 1967
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

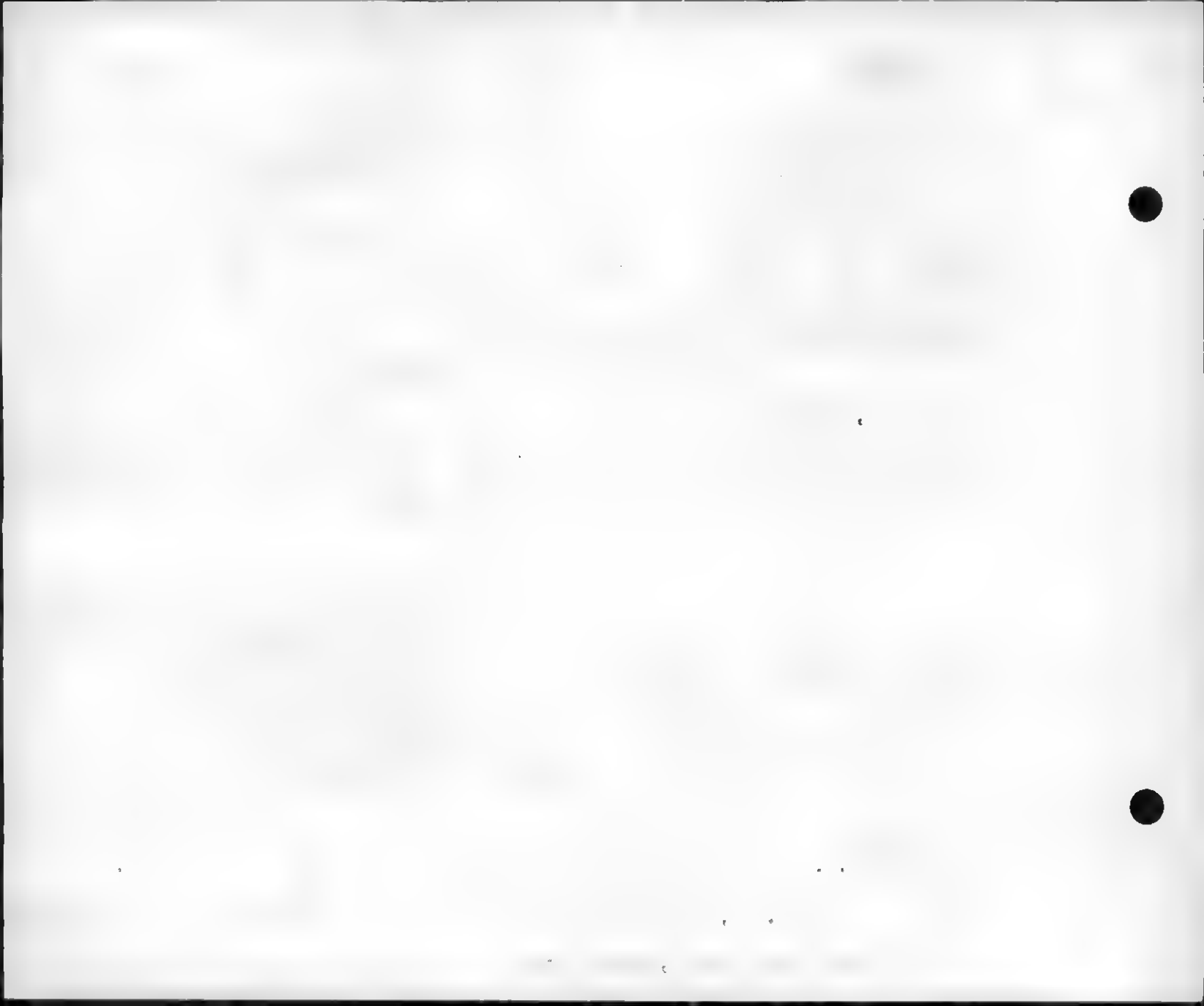
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 see Birth Cert. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11346

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Res. denoted before admission) a. STATE MD b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN IS 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		e. STREET ADDRESS NAVAL HOSPITAL Park Ave.	
3 NAME OF DECEASED (Type or print) First ANDREZ Middle MONTAG Last RICE		4. DATE OF DEATH Month DECEMBER Day 15 Year 19 67	
5 SEX MALE	6 COLOR OR RACE NEG	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 15 DEC 67
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years lost birthday) 1 IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) SAINT MARY'S md
13. FATHER'S NAME ELMER M. RICE		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT ALBERTA MARIE RICE		Address PARK AVE LEONARDTOWN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE BILATERAL ATELECTOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) PREMATURITY & IMMATURITY DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 15 DEC , 19 67 , to 15 DEC , 19 67 that (I) (we) last saw the deceased alive on 15 DEC , 19 67 , and that death occurred at 11:00 PM , from causes and on the date stated above			
22a. SIGNATURE G.P. SWARTZ, MD, MC, USN		22b. DATE SIGNED 16 DEC 1967	
22c. PHYSICIAN'S NAME (Type) G.P. SWARTZ, MD, MC, USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Dec. 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist Cemetery	23d. LOCATION (City or Town) (County) (State) Leonardtown Maryland
24. FUNERAL DIRECTOR Mattingley Funeral Home, Leonardtown, Md		25a. REC'D BY REGISTRAR DEC 21 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

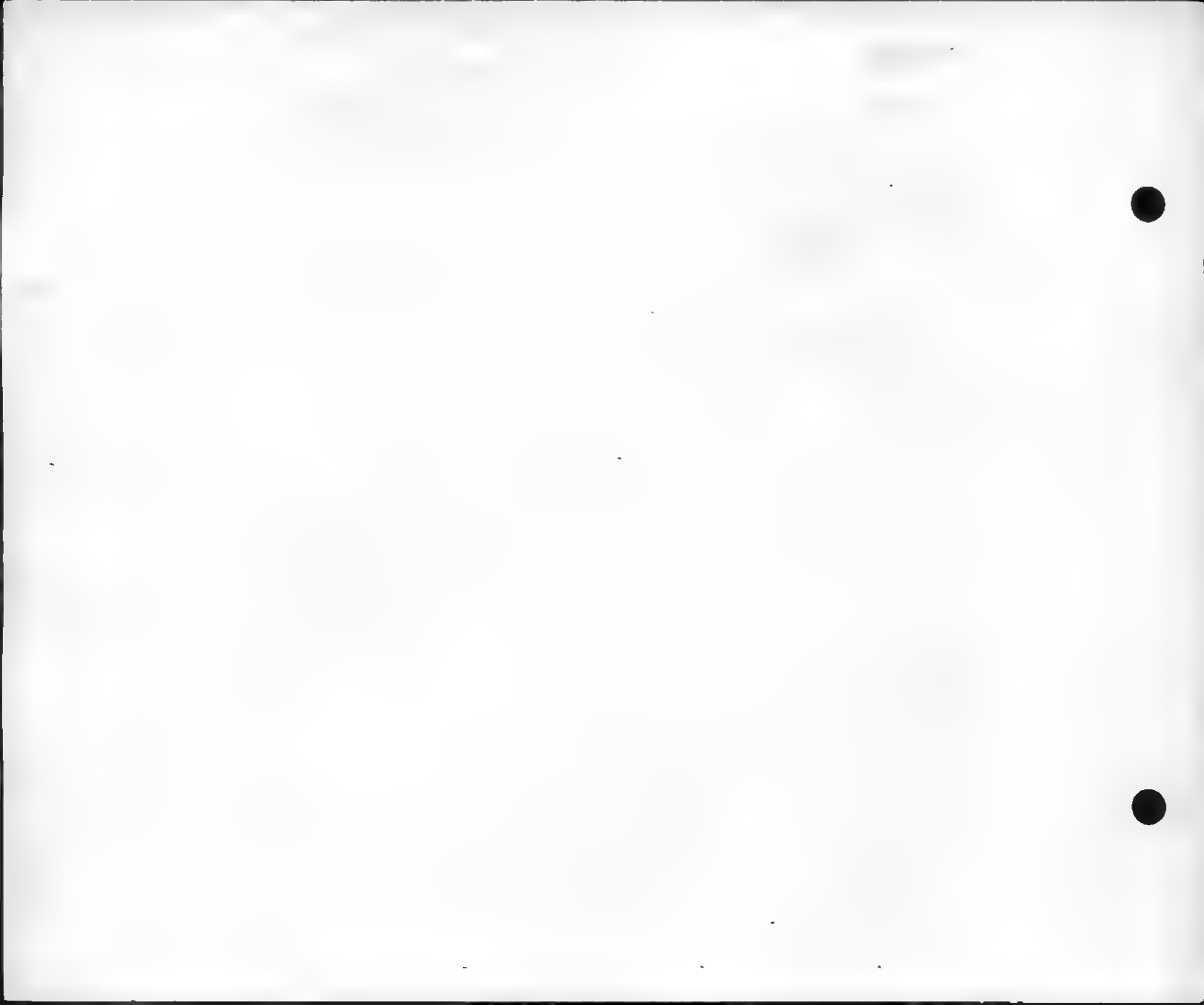
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Anne Kicketts</u>		4. DATE OF DEATH <u>Dec. 24</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1932</u>
9. AGE (In years and months) <u>35 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Kicketts</u>		14. MOTHER'S MAIDEN NAME <u>Effie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222</u>	
17. INFORMANT <u>Effie</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries - Severe</u> DUE TO (b) <u>Trauma from Auto Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Highway</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>5:45 pm 12/29/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John H. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/24/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>12/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brownwood</u>	23d. LOCATION (City or Town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Ernest C. Gartner, Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> <u>401 Randolph Road Wheaton</u>		d. STREET ADDRESS <u>3109 Verona Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Antionette</u> First <u>WETTIE</u> Middle <u>C</u> Last <u>Rodgers</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1889</u> 9. AGE (In years last birthday) <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>
13. FATHER'S NAME <u>William Robert</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>220-51-0710</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aneurysm of Aorta</u> DUE TO (c) <u>Atherosclerosis of Aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk</u> <u>YRS.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident, Parkinsonism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>67</u> , and that death occurred at <u>3:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/29/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>	22d. ADDRESS <u>4115 Colie Drive, Wheaton, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE THEREOF <u>Jan. 2, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Thomas J. Thomas</u>	25a. REC'D BY REGISTRAR <u>IAN</u> 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



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7311

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14350

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN lb 5yrs. 5mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home		d. STREET ADDRESS 9811 Hartford Road	
3 NAME OF DECEASED (Type or print) Mrs. Mary Alice Schneider		4 DATE OF DEATH Dec 2 1967	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 25 1894
9 AGE (In years last birthday) 73 yrs		10 IF UNDER 1 YEAR 2 Months 2 Days 0 Hours 0 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Shimp		14. MOTHER'S MAIDEN NAME Iva M. Montgomery	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 213-56-7496	
17 INFORMANT Methodist Home Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 2 YRS.		INTERVAL BETWEEN ONSET AND DEATH 2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 4/1/63 to 12/2/67 , that (I) (we) last saw the deceased alive on 11/28/67 , and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Henry C. Scruggs		22b. DATES GIVED 12/2/67	
22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-5-67	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or town) (County) (State) BALLO Md
24 FUNERAL DIRECTOR C. F. EVANS & SON 8802 Newfork Rd		25a. REC'D BY REGISTRAR DEC 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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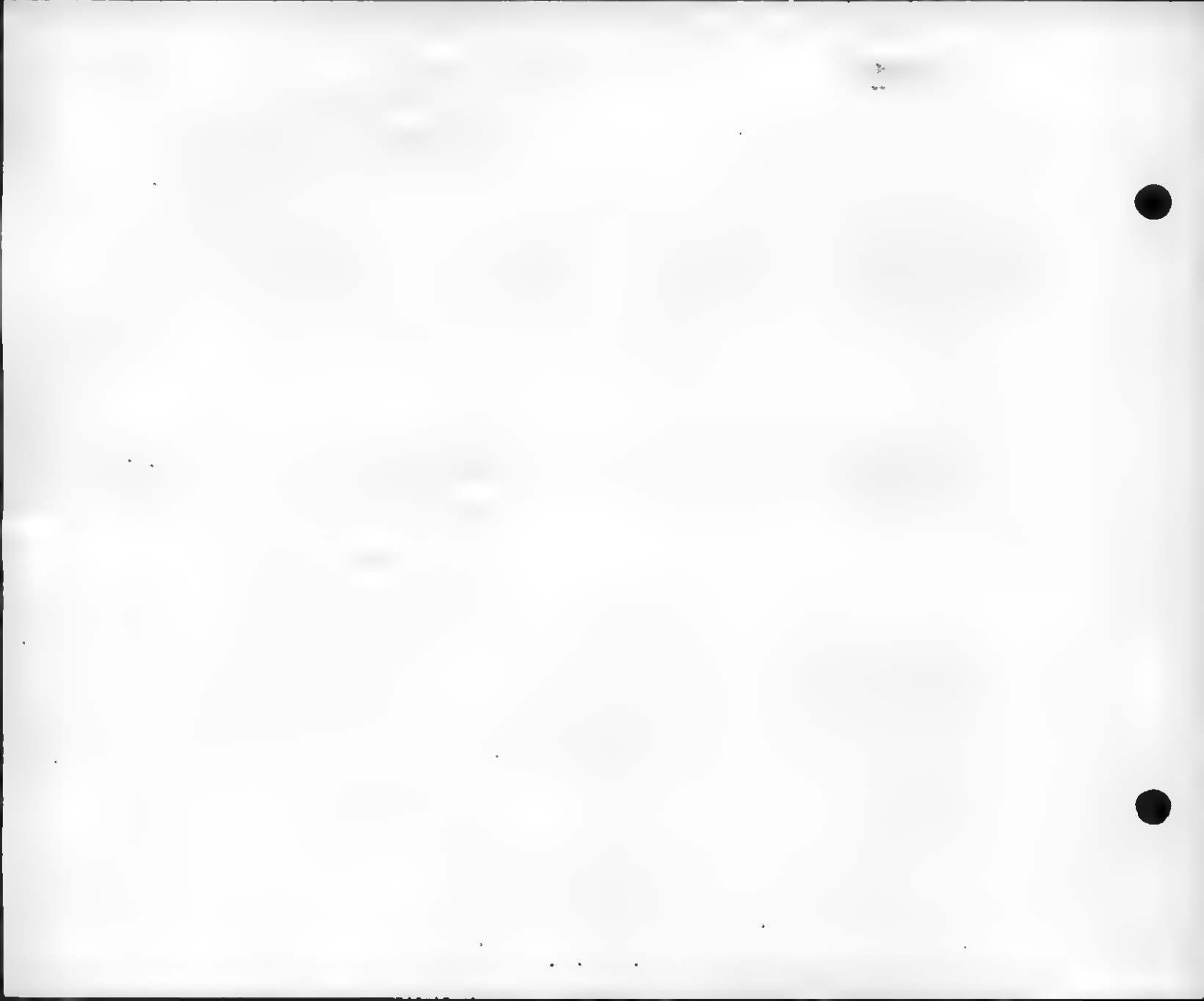
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>3051 Idaho Ave. NW</u>	
3. NAME OF DECEASED (Type or print) <u>Eleanor F. Schnoor</u>		4. DATE OF DEATH <u>Dec 20 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1887</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rochester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Frank F. Warth</u>		14. MOTHER'S MAIDEN NAME <u>Mary T. Weigel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>114 143748</u>	
17. INFORMANT <u>RANDOLPH HILLS NURSING HOME'S RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>66</u> , to <u>12/20</u> , 19 <u>67</u> , that (1) (was) last saw the deceased alive on <u>12/20</u> 19 <u>67</u> , and that death occurred at <u>8 A.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u>		22b. DATE SIGNED <u>12/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Rochester, New York.</u>	
24. FUNERAL DIRECTOR <u>A. Don. DeVol</u>		25a. REC'D BY REGISTRAR <u>D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>		DATE <u>JAN 2 1968</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 135			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY in 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Junction (Annapolis)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS Box 46			
3. NAME OF DECEASED (Type or print) First Hugo Middle Herman Last Schwarz				4. DATE OF DEATH Month December Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-98		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 69 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government			10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Carl Schwarz				14. MOTHER'S MAIDEN NAME Teresa Knitzinger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes No German Navy			16. SOCIAL SECURITY NO		17. INFORMANT Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarct 7201 DUE TO Anterior chest heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchitis emphysema DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1965 to Dec. 22, 1967 , that (I) (we) last saw the deceased alive on Dec. 22, 1967 , and that death occurred at 9:30 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Abraham W. Danish			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 25, 1967		
22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH			22d. ADDRESS 1106 SPRING ST. S.S. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/23/67	23c. NAME OF CEMETERY OR CREMATORY FT LINCOLN CREMATORY		23d. LOCATION (City or Town) (County) (State) RODGERS MD.		
24. FUNERAL DIRECTOR Arthur Davis		ADDRESS 350 WASH BLDG, LAUREL, MD.		25a. RECEIVED BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



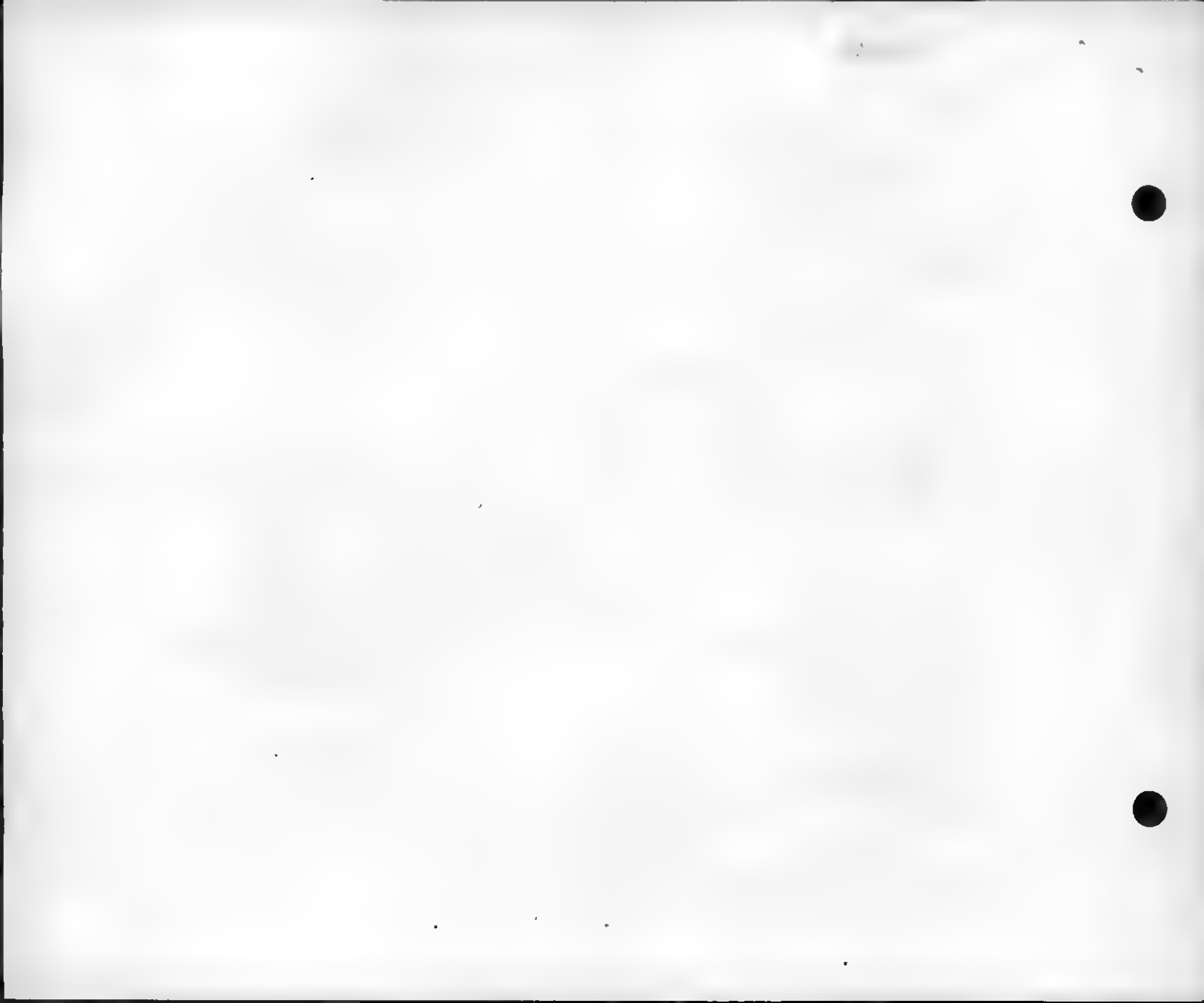
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, D.C. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c LENGTH OF STAY IN 1b 34 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d STREET ADDRESS 1600 16th Street, N.W.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Joseph (NMN) Scrippens				4 DATE OF DEATH Month December Day 23 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 March 1925		9 AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Lithographer		10b. KIND OF BUSINESS OR INDUSTRY Lithographic Co.		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Michael Scrippens				14 MOTHER'S MAIDEN NAME Anna Kohan			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1943-45		16 SOCIAL SECURITY NO. 199-14-3960		17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Aortic Insufficiency DUE TO (c) Rheumatic Valve Disease						INTERVAL BETWEEN ONSET AND DEATH 2 days 12 years 20 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 days following open heart surgery for aortic valve replacement.						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 19 November 19 67 to 23 Dec. , 19 67 , that (X) (we) lost saw the deceased alive on 23 December 19 67 , and that death occurred at 10:15 AM , from causes and on the date stated above							
22a. SIGNATURE Eric H. Johnson MD				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 1967 23 December	
22c PHYSICIAN'S NAME (Type) Eric H. Johnson, MD				22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-27-67		23c NAME OF CEMETERY OR CREMATORY St. Mary's G. C. Cem.		23d LOCATION (City or Town) (County) (State) Pringle, Penna	
24 FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				25a REC'D BY REGISTRAR DATE DEC 29 1967		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

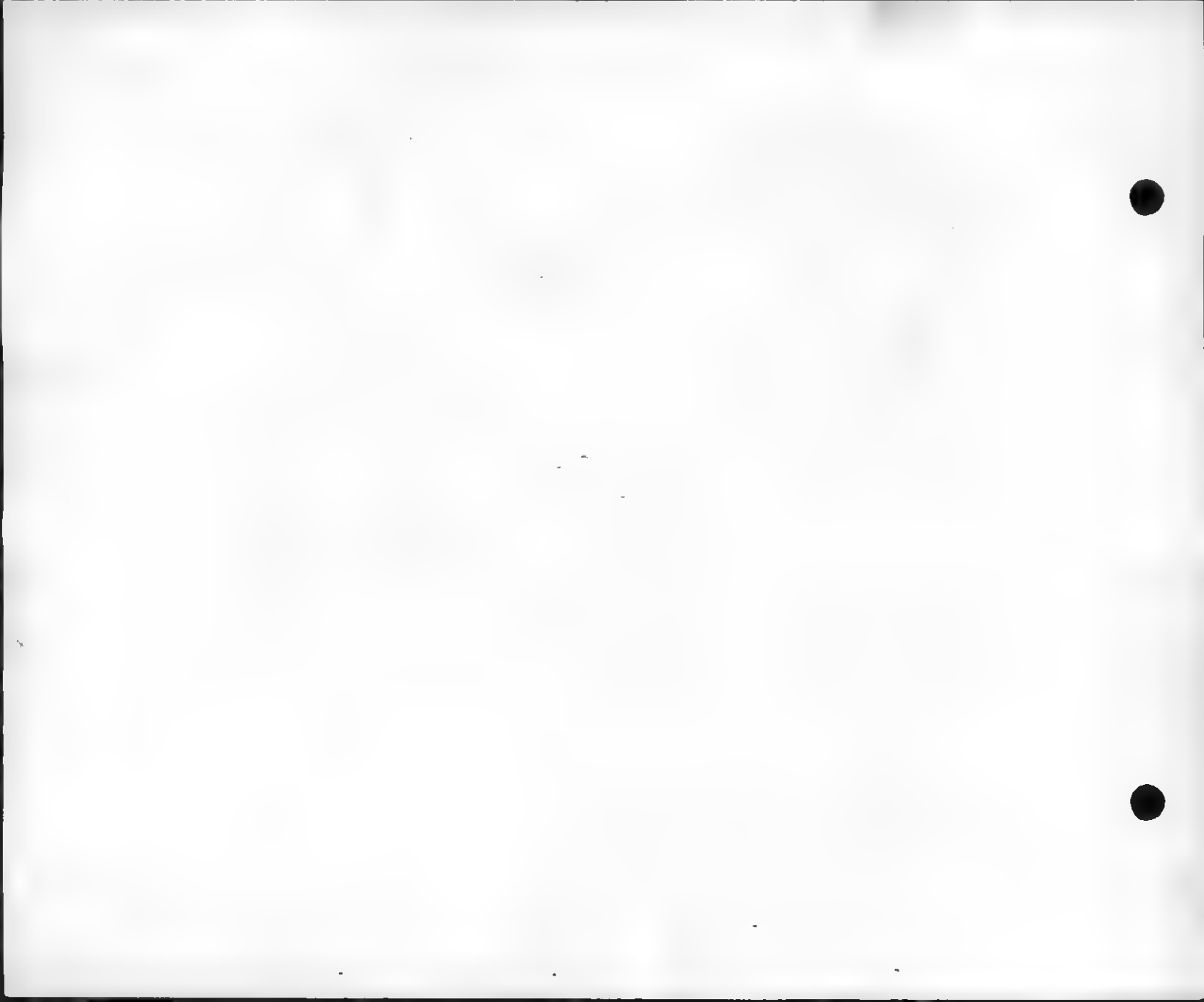
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17354

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.				d. STREET ADDRESS 717 BAYFIELD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GEORGE BEALE SEEK				4 DATE OF DEATH Month 12 - Day 4 Year 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-97	9 AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME RICHARD SEEK				14. MOTHER'S MAIDEN NAME ISABEL COLE			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579-22-8604		17 INFORMANT MAY SEEK - NIECE		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 7301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVA. BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Walter (City or town) (County) (State)			
22. DATE SIGNED DEC. 4, 1967							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery		23d. LOCATION (City or Town) (County) (State) Colesville, Maryland	
24. FUNERAL DIRECTOR John B. Thomas Address 4324 Georgia Avenue Silver Spring, Maryland				25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>18 days/1 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>501 Sligo Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kimberly Ruth Seck</u> First Middle Last				4. DATE OF DEATH <u>12</u> <u>20</u> <u>1967</u> Month Day Year		5. AGE (in years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
6. SEX <u>Female</u>		7. COLOR OR RACE <u>White</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>9-17-61</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>school</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Theodore Seck</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Seck VANCE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Theodore Seck</u> Address <u>2d. Hospital Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Reaction to Conflagration</u> DUE TO (b) <u>Burns of 65% of Body</u> DUE TO (c) <u>Surface</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased playing with electric stove and clothing caught fire</u>							
20c. TIME OF INJURY Month, Day, Year <u>10:30 a.m. 12-2-67</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) <u>SILVER SPRING</u> (County) <u>MONTGOMERY</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <u>DEC. 21, 1967</u>	
ACTUAL SIGNATURE <u>Belden R. Neap</u> EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>8434 Ga. Ave. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/23/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		23d. LOCATION (city, town or county) <u>Pockville, Maryland</u> (State)		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

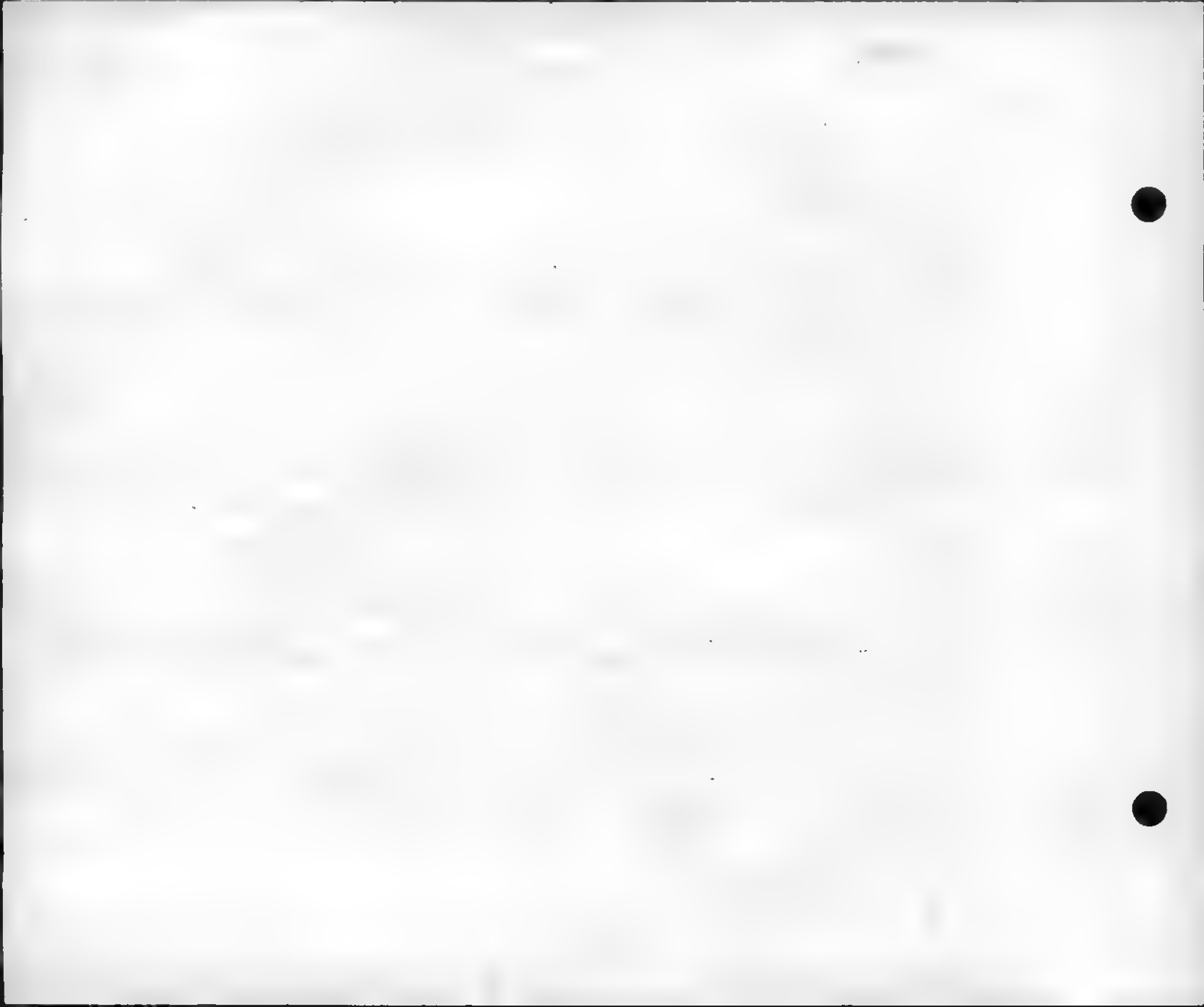
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17356

17356

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS RT. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First VIOLA Middle RACHEL Last SELBY				4 DATE OF DEATH Month DECEMBER Day 2 Year 19 67			
5 SEX FEMALE	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-01		9 AGE (In years last birthday) yrs. 66	10. UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ZETTA EASTON				14. MOTHER'S MAIDEN NAME MINNIE MUSGROVE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 217-34-5282		17. INFORMANT Address MEDICAL RECORDS MONT. GEN. HOSP. OLNEY MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) TOXEMIA-SEPTISEMIA DUE TO 1 DAY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PANCREATIC ABSCESS DUE TO WKS - (c) PANCREATITIS, NECROTIC 8-12 WKS							INTERNAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INFARCTION TERMINAL LUNG - DUE TO ADHESIONS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from AUGUST, 1967 to DEC 2, 1967 , that (1) (we) lost saw the deceased alive on DEC 2, 1967 , and that death occurred at 8:45 A.M. from causes and on the date stated above.							
22a. SIGNATURE Donald F. Jones				22b. DATE SIGNED DEC 2, 1967		22c. PHYSICIAN'S NAME (Type) Donald F. Jones	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-5-67		23c. NAME OF CEMETERY OR CREMATORY GRISTLAWN		23d. LOCAT ON (City or Town) (County) (State) N. FRIENDSHIP MD.	
24. FUNERAL DIRECTOR Highinbottom - Shook				25a. REC'D BY REGISTRAR DEC 11 1967		25b. REG STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Corroll Hall Sanatorium</u>				d. STREET ADDRESS <u>CARROLL HALL SANITARIUM</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>A.</u> Last <u>Shaffer</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 7, 1874</u>	
9. AGE (in years last birthday) <u>93</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CLEVELAND OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JAY P. PAWLEY</u>			
14. MOTHER'S MAIDEN NAME <u>IVA GISSELA CANFIELD</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>286-24-6832D</u>				17. INFORMANT <u>CUL HENRY L. SHAFFER - WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEWILITY</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> , 19 <u>67</u> , to <u>DEC. 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC. 22</u> , 19 <u>67</u> , and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry M. Lowden</u>				22b. DATE SIGNED <u>12/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>				22d. ADDRESS <u>5206 Norway Dr., Beltsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>12/23/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>Calmar Maryland 20606 MD</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - Washington, DC</u>				25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

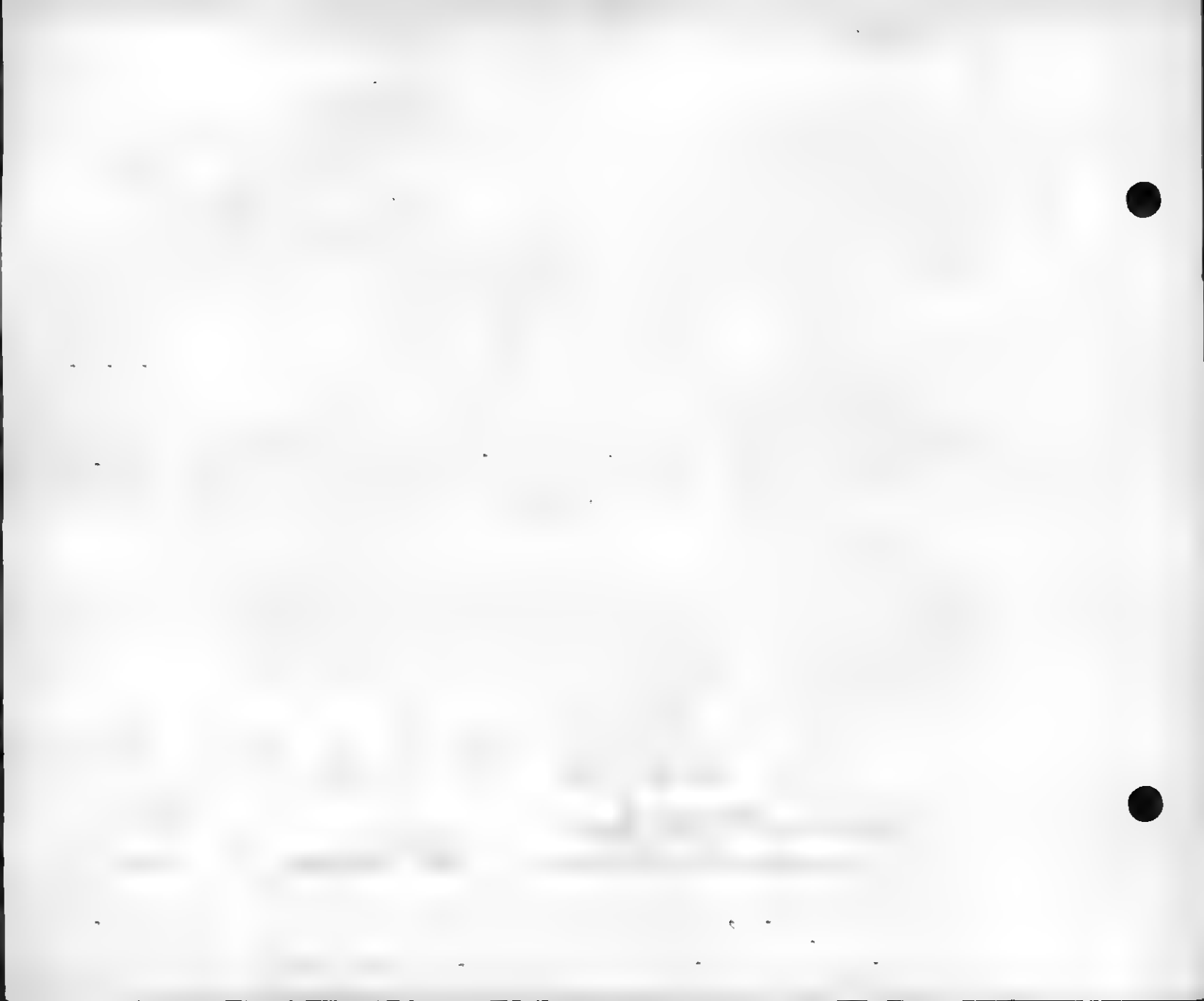
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Pennsylvania</u> b COUNTY <u>Rockville</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>48 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d STREET ADDRESS <u>1122 Sycamore Street</u>	
3 NAME OF DECEASED (Type or print) <u>SARA</u> First <u>A.</u> Middle <u>Shaeffer</u> Last		4 DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-5-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Issac Morgan</u>		14 MOTHER'S MAIDEN NAME <u>Ida May Docherty</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>182-36-3908</u>	
17. INFORMANT <u>Mrs. John E. Grubb</u>		Address <u>705 Winhall Way, Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>CEREBRAL ARTERIAL SCLEROSIS</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Oct 19</u> , 19 <u>67</u> , to <u>Dec 6</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>Dec 6</u> , 19 <u>67</u> , and that death occurred at <u>2:35 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jonathan M. Williams</u> M.D.		22b. DATE SIGNED <u>Dec-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>		22d. ADDRESS <u>808 Pershing Dr. Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Dec. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenside Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Connelville Penna.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
Address <u>8434 Georgia Avenue</u>		DATE <u>DEC 11 1967</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

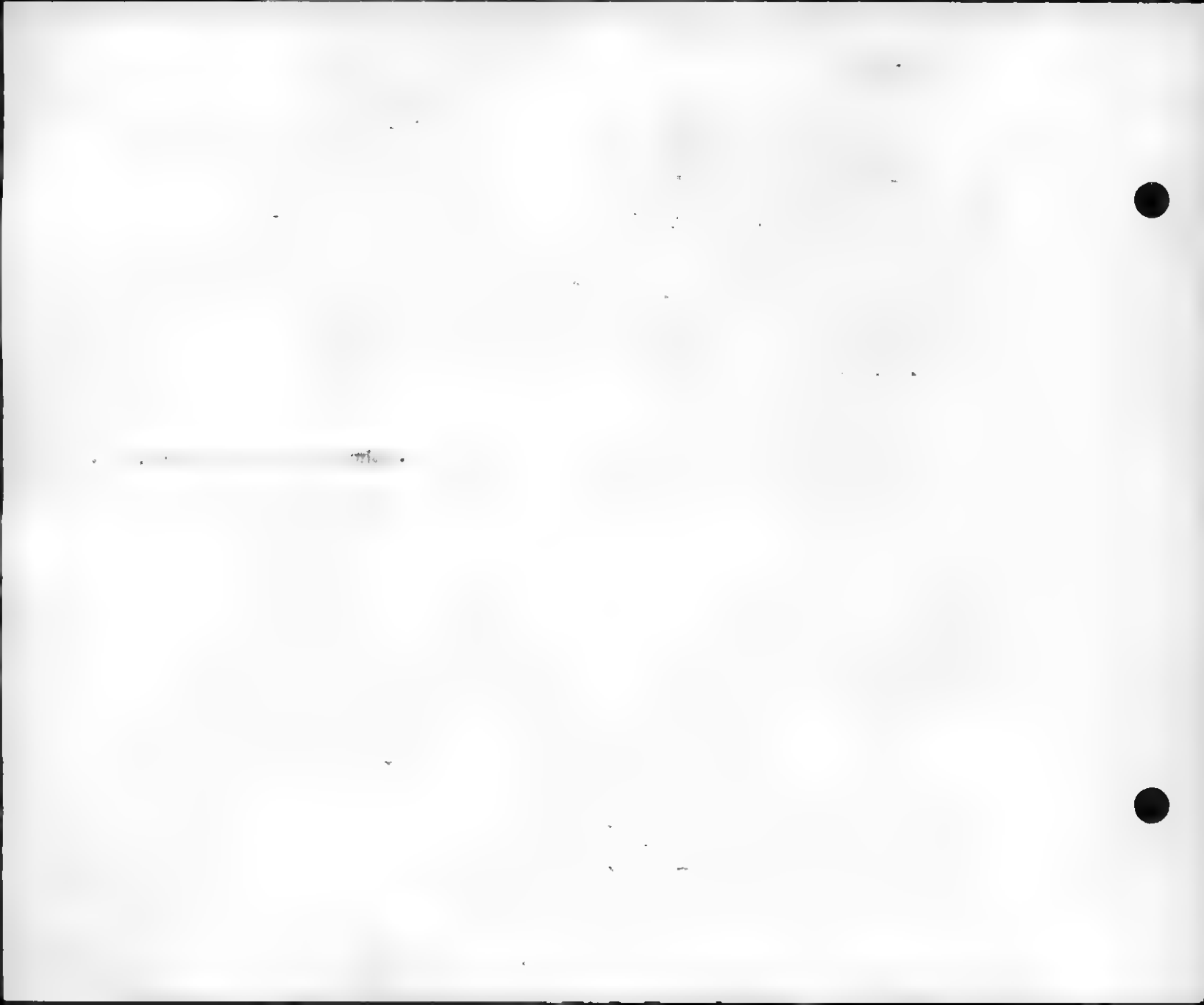
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 91
6M 1/67

Items 18&21 Film 396 12-2 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c LENGTH OF STAY in lb 7 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e STREET ADDRESS 4207 East West Highway	
3 NAME OF DECEASED (Type or print) First Ralph Middle J. Last Sheffer		4 DATE OF DEATH Month 12 Day 6 Year 1967	
5 SEX male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/12/90
9 AGE (in years last birthday) 77 yrs		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.	
10b KIND OF BUSINESS OR INDUSTRY self employed		11 BIRTHPLACE (State or foreign country) Wisconsin	
12 CITIZEN OF WHAT COUNTRY? U S A		13 FATHER'S NAME Eddy Sheffer	
14 MOTHER'S MAIDEN NAME Myrtle Maxon		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes H W I	
16 SOCIAL SECURITY NO 577-40-6850		17 INFORMANT Charlotte M. Sheffer Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute massive intracerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, public bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED DEC. 6, 1967	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF Dec 9, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DATE DEC 11 1967	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1360

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3907 Warner St.</u>						d. STREET ADDRESS <u>3907 Warner St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>D</u> Middle <u>Sheldon</u> Last						4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/6/05</u>		9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 24 HRS Month <u>02</u> Year <u>02</u> Days <u>02</u> Hours <u>02</u> Min <u>02</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Queens County, N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James G. DeBevoise</u>						14. MOTHER'S MAIDEN NAME <u>Catherine MacLardy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-46-2918</u>		17. INFORMANT <u>Husband - James Sheldon</u>				Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> <u>1727</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Oligo blastoma</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>11/15, 1967</u> to <u>present</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>12/29/1967</u> , and that death occurred at <u>3:15</u> M. from causes on and on the date stated above.											
22a. SIGNATURE <u>John B. Umhau</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/30/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAY MD</u>						22d. ADDRESS <u>8805 Conn. Ave. Chevy Chase Md.</u>					
23a. BURIAL, CREMATION, EMBALMING		23b. DATE THEREOF <u>4 Jan 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Rockville Mont Md.</u>			
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>						ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



10 1

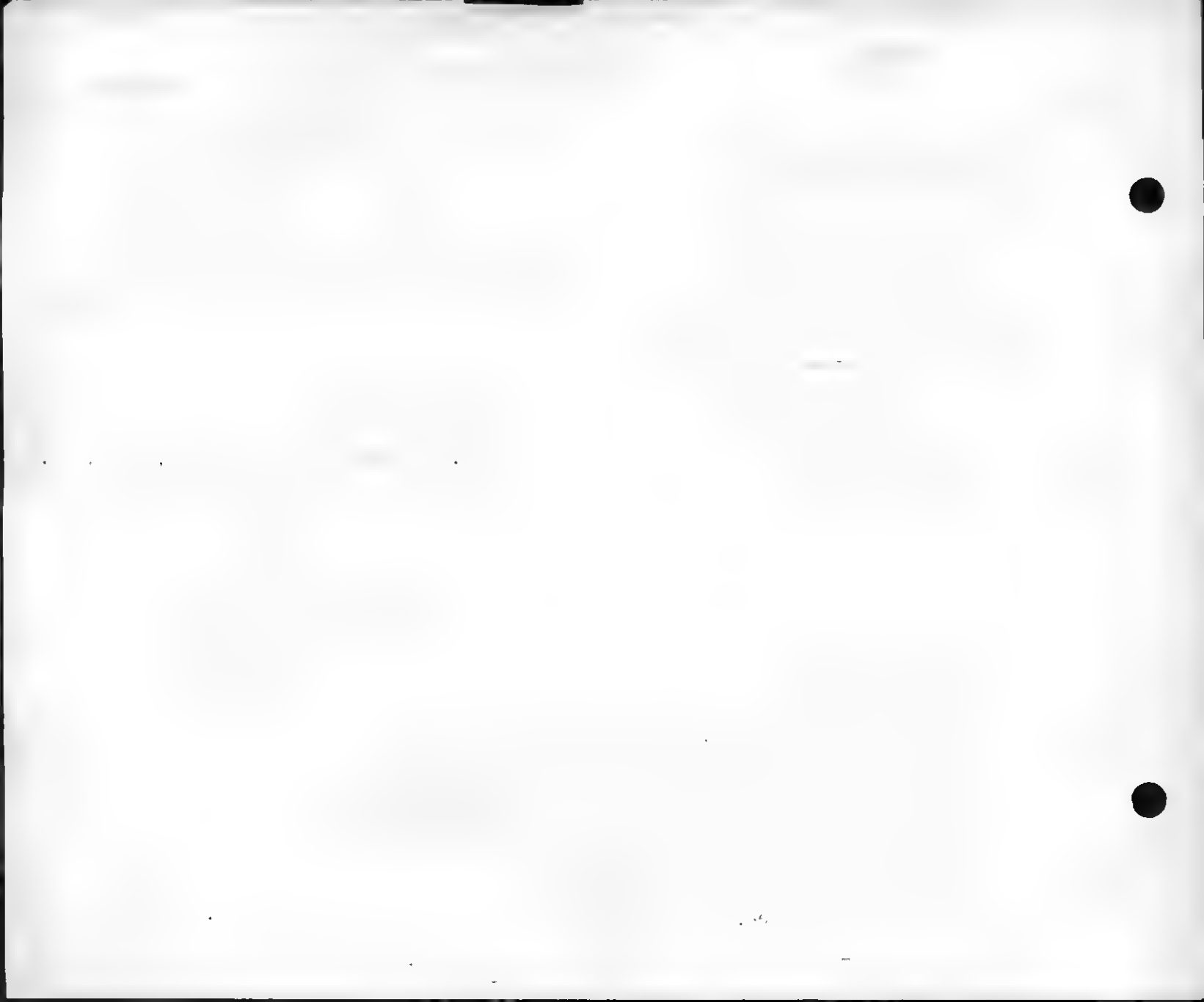
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1061
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. Boyds</u>				c. LENGTH OF STAY IN 1b <u>5 1/2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 17 B.</u>				e. STREET ADDRESS <u>Box 17. B.</u>			
3 NAME OF DECEASED (Type or print) <u>William Arthur Shiflet</u>				4 DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1967</u>			
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 7, 1913</u>	9 AGE (In years last birthday) <u>54</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cons. Engineer</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11 BIRTHPLACE (State or foreign country) <u>Ohio</u>		
13 FATHER'S NAME <u>Elisah Shiflet</u>			14 MOTHER'S MAIDEN NAME <u>Virginia Fowler</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOCIAL SECURITY NO. <u>284-07-6346</u>		17 INFORMANT Address <u>Mrs. Margaret Simpson Shiflet, Boyds, Md.</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John E. Ball</u>		M.D.		22. DATE SIGNED <u>12/9/67</u>			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>13 Dec. 67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mount Comfort Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Fairfax Co., Virginia</u>			
24. FUNERAL DIRECTOR <u>B. Earle Mountcastle</u> <u>Cunningham-Mountcastle Funeral Home, Woodbridge, Va.</u>				25a REC'D BY REGISTRAR <u>DEC 13 1967</u>		25b REG. STRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

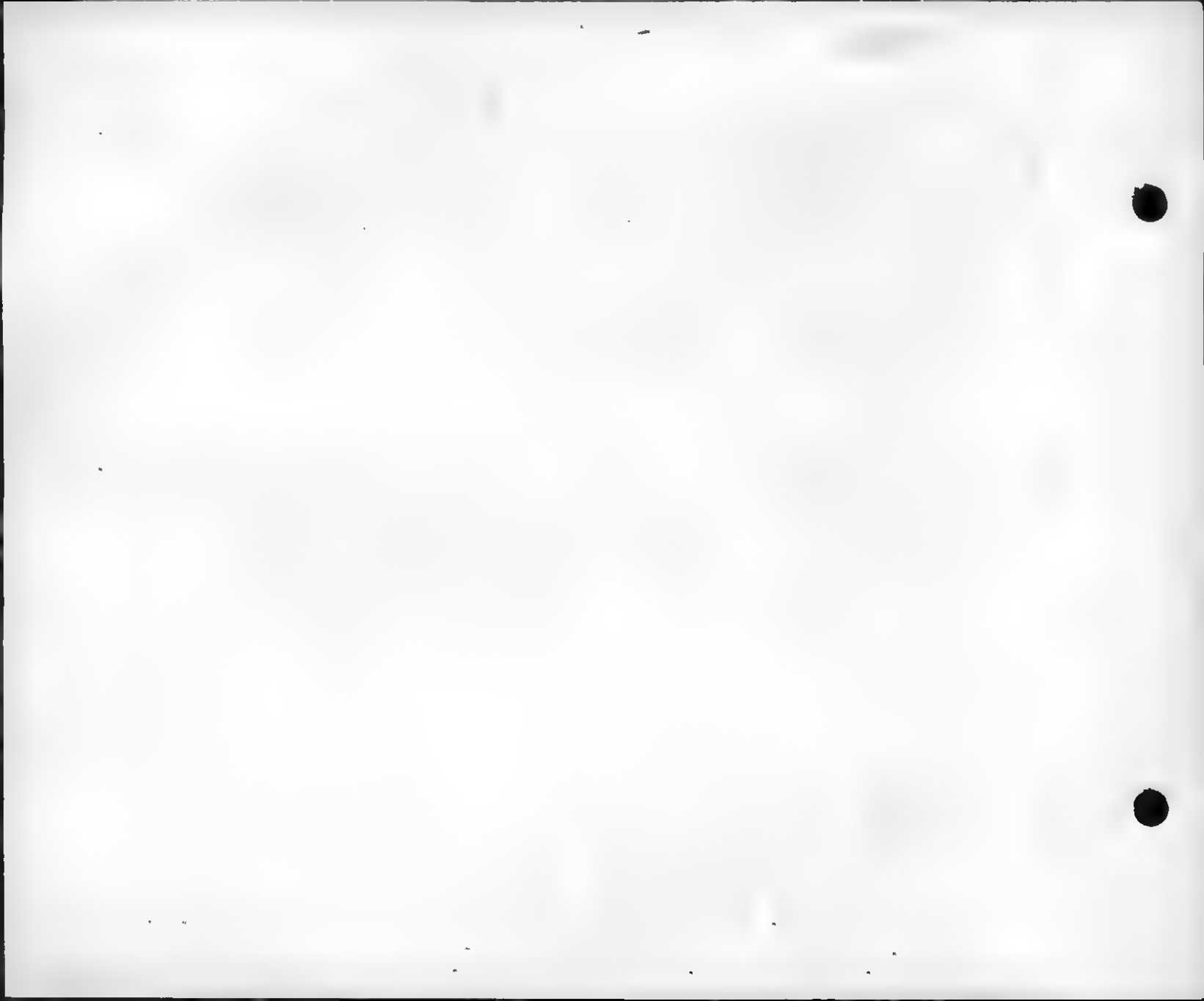
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. LENGTH OF STAY IN <u>1 yr. 4 mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Abby</u> Last <u>Shives</u>		4. DATE OF DEATH <u>Dec 22, 1967</u>	
5. SEX <u>♂</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1879</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Station Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Station</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hancock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-26-8539-A</u>	
17. INFORMANT <u>John E. Cannon</u> Address <u>5 Ruben Court Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X</u> DUE TO <u>Leukemia - General Debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute</u> DUE TO <u>Cord.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Dec 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 18</u> , 19 <u>67</u> , and that death occurred at <u>11:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Bufalino</u> M.D.		22b. DATE SIGNED <u>Dec 22, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino</u>		22d. ADDRESS <u>1429 University Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wendwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>John E. Cannon</u> Address <u>134 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John E. Cannon</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

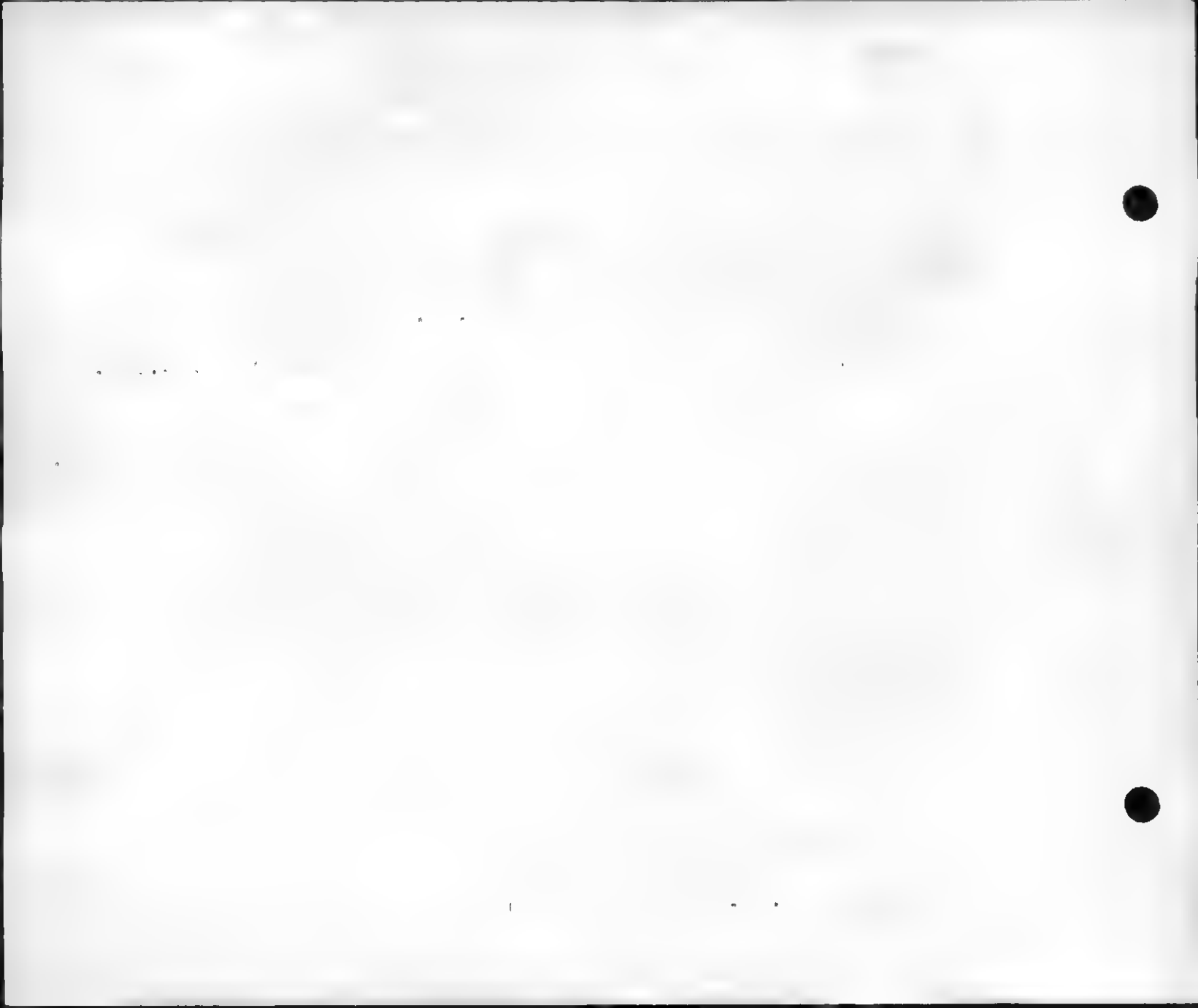
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Filed 1/5/68

CERTIFICATE OF DEATH

11363

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WASH.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> <u>21.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium Route # 2</u>		d. STREET ADDRESS <u>Route # 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA JANE SHIVES</u>		4. DATE OF DEATH Month Day Year <u>DEC. 14 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.11.1879</u>
9. AGE (In years last birthday) <u>86.88</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON COUNTY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS LEO YOUNKER RURAL 2 HANCOCK MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Advanced senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>67</u> to <u>Dec 14</u> , 19 <u>67</u> , that <u>we</u> last saw the deceased alive on <u>Dec 14 1967</u> , and that death occurred at <u>10P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Marvin Wadler</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisc. Av. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12.17.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ORCHARD RIDGE</u>	23d. LOCATION (City or town) (County) (State) <u>RURAL HANCOCK WASHINGTON MD</u>
24. FUNERAL DIRECTOR <u>Howard H. Lane Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles George</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7364

CERTIFICATE OF DEATH

17364

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>C</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>6030 Vista Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>James</u> Last <u>Shugars</u>		4 DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>Caus.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/22/1889</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Louden County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Shugars</u>		14. MOTHER'S MAIDEN NAME <u>Cassandrew Stoneburner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>577-10-0399</u>	
17. INFORMANT <u>Delia H. Shugars</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cerebrovascular disease 6 mm</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 11, 1967</u> to <u>DEC 3, 1967</u> that (I) (<u>was</u>) last saw the deceased alive on <u>3 DEC 1967</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter G. Goor</u>		22b. DATE SIGNED <u>12/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOR MD</u>		22d. ADDRESS <u>2304 SHOREFIELD RD WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Dec. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Culpeper National</u>		23d. LOCATION (City or Town) (County) (State) <u>Culpeper Virginia</u>	
24. FUNERAL DIRECTOR <u>Jackie L. Dugger - see funeral home</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>734 College Parkway</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brian Michael Shulman</u>		4. DATE OF DEATH Month Day Year <u>Dec 22 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26 1966</u>
9. AGE (In years lost birthday) yrs <u>1</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barry Shulman</u>		14. MOTHER'S MAIDEN NAME <u>Myrna Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Mathew - same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>9210 ASPHYXIA</u>			
DUE TO (b) <u>ASPIRATION OF FOOD</u>			
DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Aspirated piece of apple. Person eating</u>	
20c. TIME OF INJURY Month, Day, Year Hour AM PM <u>10 12/22 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Montgomery MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/22/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ADATH ISRAEL</u>		23d. LOCATION (City or Town) (County) (State) <u>RENTON NJ</u>	
24. FUNERAL DIRECTOR <u>Goodley Funeral Home</u>		ADDRESS <u>4217-9th Ave.</u>	
25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 6 & 7 Film 6-3 1/3/68 KK
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>1yr 3 mos.</u>		d. STREET ADDRESS <u>9906 East Bexhill Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Sibert</u> Last <u>Sibert</u>		4 DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30, 1896</u>
9. AGE (in years lost birthday) <u>71</u> yrs		F UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Van Shelby Perkins</u>		14. MOTHER'S MAIDEN NAME <u>Frances Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>403-01-8586 D</u>	
17. INFORMANT <u>Boyd Sibert - See Item No. 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Artery Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1962</u> to <u>Dec 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 15, 1967</u> , and that death occurred at <u>2:00</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Harell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Harell MD</u>		22d. ADDRESS <u>5516 Nebraska Ave DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
ADDRESS <u>5130 Wisconsin Ave. N.W.</u> <u>Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

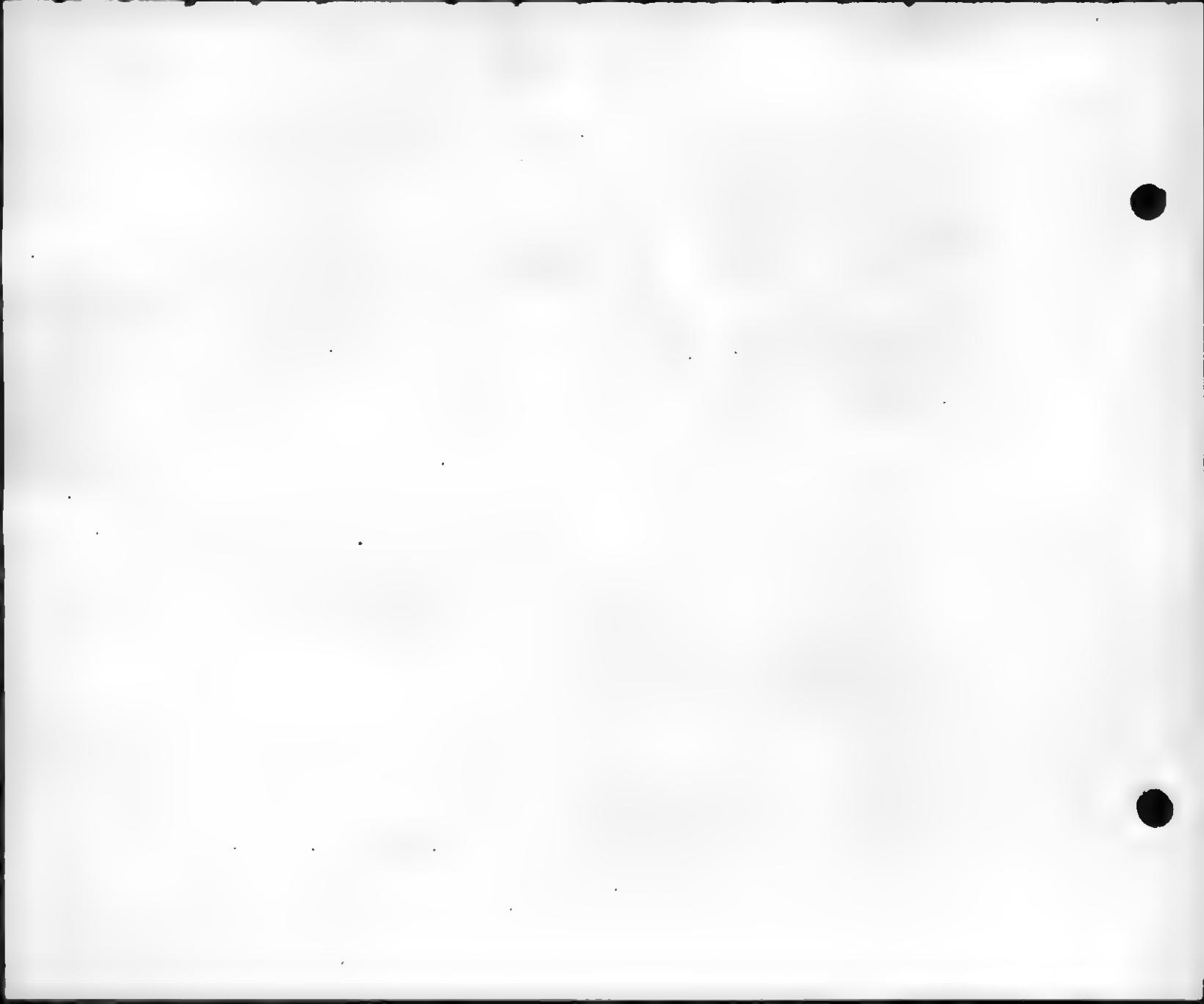


1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Item #2a,b,c & d Film #139
11367
Item #23b-4-11-1396

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING MD		c. LENGTH OF STAY IN 1b Mo	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Mont.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DELLA VISTA NURSING HOME		e. STREET ADDRESS 10430 Brookmore Drive		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELLA MAE HAUKE SKINNER		4. DATE OF DEATH Dec. 6 - 1967		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 10, 1889		9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Govt - Retired		11. BIRTHPLACE (County & State, or foreign country) Yacoma, Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Charles Hauke		14. MOTHER'S MAIDEN NAME Carrie Duncan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. HOMER SULLIVAN JR. S.S. MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cardio-Vascular Renal Disease DUE TO (c) 1 Yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital), attended the deceased from 10/16 , 1967, to 12/6 , 1967, that (I) (we) last saw the deceased alive on 12/4 , 1967, and that death occurred at M , from the causes and on the date stated above.								
22a. SIGNATURE Harold Heger		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/6/67				
22c. PHYSICIAN'S NAME (Type) Harold Heger		22d. ADDRESS 5415 Conn Ave NW DC						
23a. BURIAL, CREMATION, REMOVAL (Specify) Dec 8, 1967		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.		
24. FUNERAL DIRECTOR Arthur Walters		25a. REC'D BY REGISTRAR 254 Carroll St. N.E.		25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE DEC 11 1967		



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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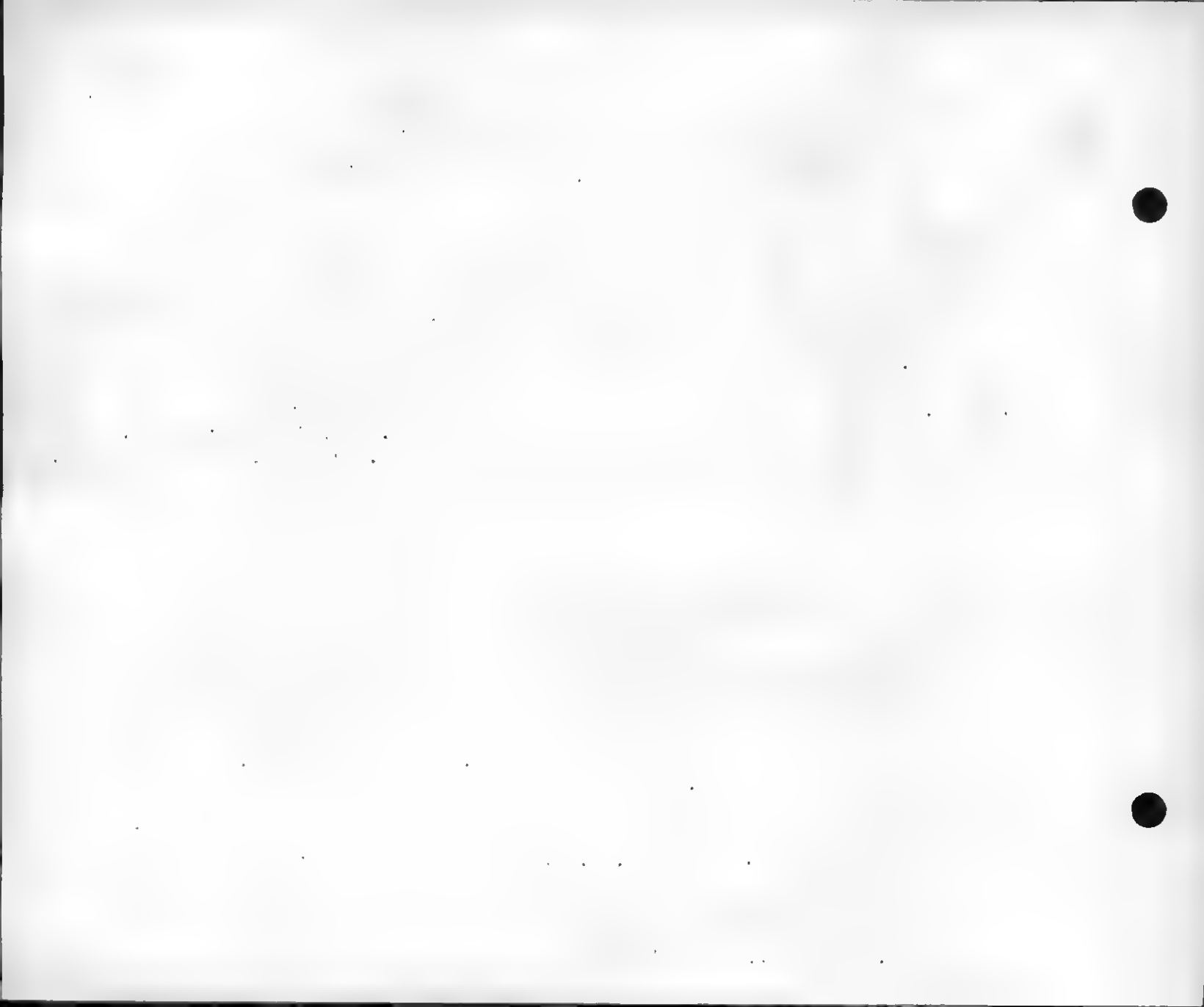
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17368

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 56 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 4513 Rena Road	
3 NAME OF DECEASED (Type or print) First Frank Middle Kane Last SLASON		4 DATE OF DEATH Month December Day 31 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1913
9. AGE (In years past birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. USN		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Staten Island, New York		12 C. I. ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Slason		14. MOTHER'S MAIDEN NAME Elizabeth Kane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 561 54 3644	
17 INFORMANT Apt. 409, Chevy Chase, Md.		Miss Helen B. Schumann, 5100 Dorset Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 58 in DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from Nov. 5 , 19 67 , to Dec. 31 , 19 67 , that (x) (we) last saw the deceased alive on Dec. 31 , 19 67 , and that death occurred 1145A M, from causes and on the date stated above			
22a. SIGNATURE <i>Frank C. Blackburn</i>		22b. DATE SIGNED Jan. 2, 1968	
22c. PHYSICIAN'S NAME (Type) Frank C. Blackburn, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/68	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 W. Broad St., Falls Church, Virginia		25a. REC'D BY REGISTRAR JAN 8 1968	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17369

7369

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN <u>91 days (12-11-67)</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>4512 HARLING LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MAE JORIE M. SLOTHOWER</u> First Middle Last 4 DATE OF DEATH <u>DEC 11 1967</u> Month Day Year		5 SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-28-99 68</u> 9 AGE (In years last birthday) <u>68</u> yrs 10 UNDER 1 YEAR Months Days 11 UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Turck</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/No/Unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>577-54-2634</u>	
17 INFORMANT <u>Son - John H. Slothower</u>		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis with intestinal obstruction</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary carcinoma of ovary</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>12 months</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>56</u> to <u>DEC</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 10 1967</u> , and that death occurred at <u>4:42</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u> MD		22b DATE SIGNED <u>12/11/67</u>	
22c PHYSICIAN'S NAME (Type) <u>DR LEO I DONOVAN</u>		22d ADDRESS <u>8218 WILSON AVE</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12-14-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Warrington Quaker Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Wellsville, Penna.</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>DEC 15 1967</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed by Dr. Beldon Korp - 12/16/67

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

*Also known as

EVA FLORA SCHMITZ

11370

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING TAKOMA PARK</u>	
c. LENGTH OF STAY IN 1b <u>36 days</u>		d. STREET ADDRESS <u>903 JACKSON AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SYLVAN MAJOR HEALTH CARE CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVA ELORA SMITH*</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1872</u>
9. AGE (In years last birthday) <u>95</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Butler</u>		14. MOTHER'S MAIDEN NAME <u>Not available</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Frank C. Kleye (same as #2)</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis is Generalized</u> <u>450.0</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>July 1938</u> to <u>2-16-1967</u> that (I) (we) last saw the deceased alive on <u>11-28-1967</u> , and that death occurred at <u>21</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>James H. Korp</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Korp</u>		22d. ADDRESS <u>7717 Canalland Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 19 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Park</u>	23d. LOCATION (City or town) (County) (State) <u>Parksmouth Va</u>
24. FUNERAL DIRECTOR <u>Arthur W. Wooters</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 21 1967</u>			



4

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377

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

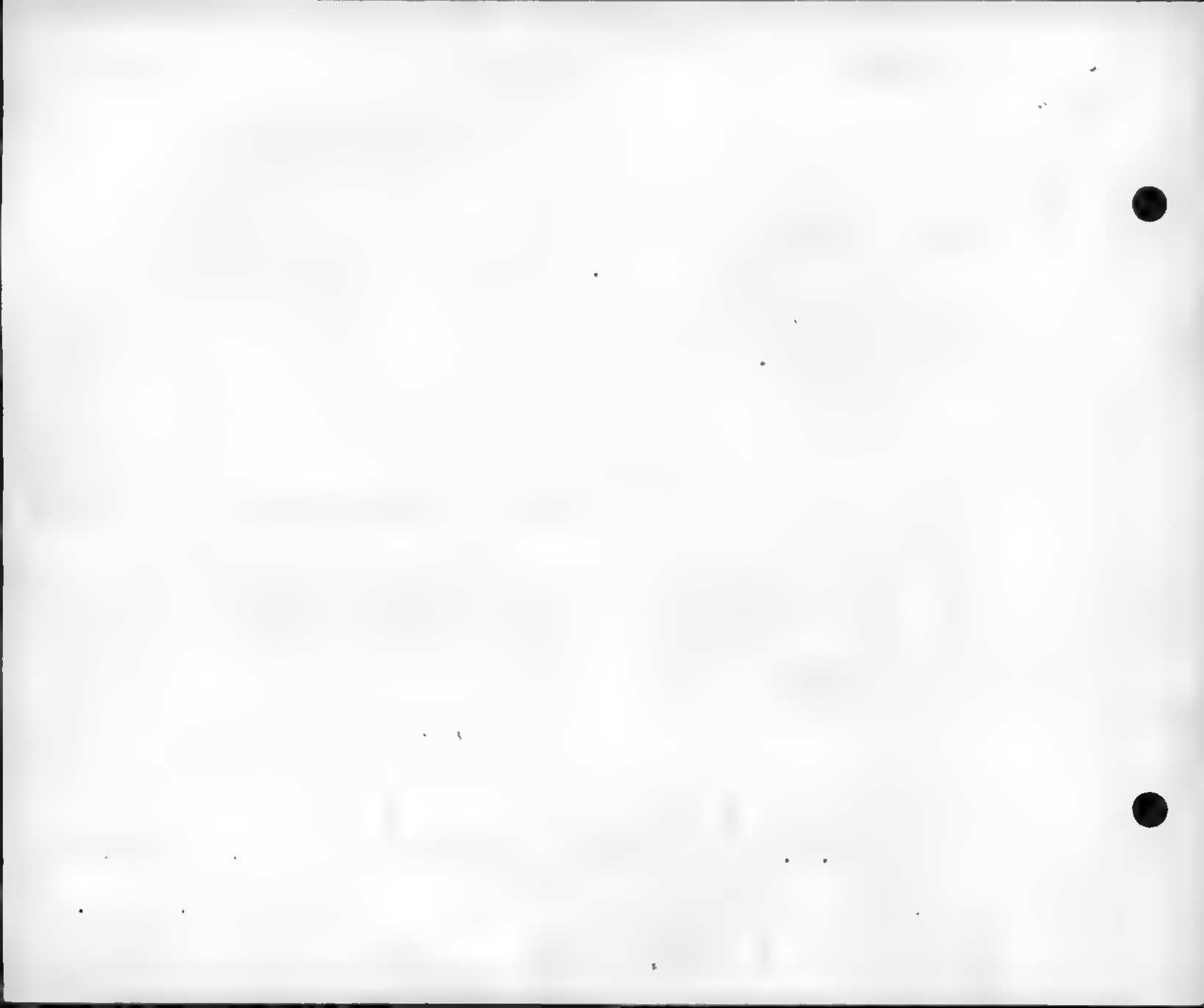
CERTIFICATE OF DEATH

14371

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
c. LENGTH OF STAY IN 1b <i>8 days</i>		d. STREET ADDRESS <i>4311 Independence St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>MADELINE</i> Middle <i>E.</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>11</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/26/1898</i>
9. AGE (in years last birthday) <i>69</i> yrs		10. UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Government Emp.</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Penn.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William B Rudy</i>	
14. MOTHER'S MAIDEN NAME <i>Alvaritta Smith</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>579-12-6893</i>		17. INFORMANT <i>daughter Arline Smith</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4:11</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>hypertensive bronchopneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/3/67</i> , 19 <i>67</i> , to <i>12/11/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>Taleham</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Jay R. Shapiro</i>		22b. DATE SIGNED <i>12/11/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. R. Shapiro</i>		22d. ADDRESS <i>8218 Wisconsin Ave, Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>12/13/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Airy</i>	23d. LOCATION (City or town) (County) (State) <i>Mt. Airy, Pa.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		25a. REC'D BY REGISTRAR <i>DEC 15 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

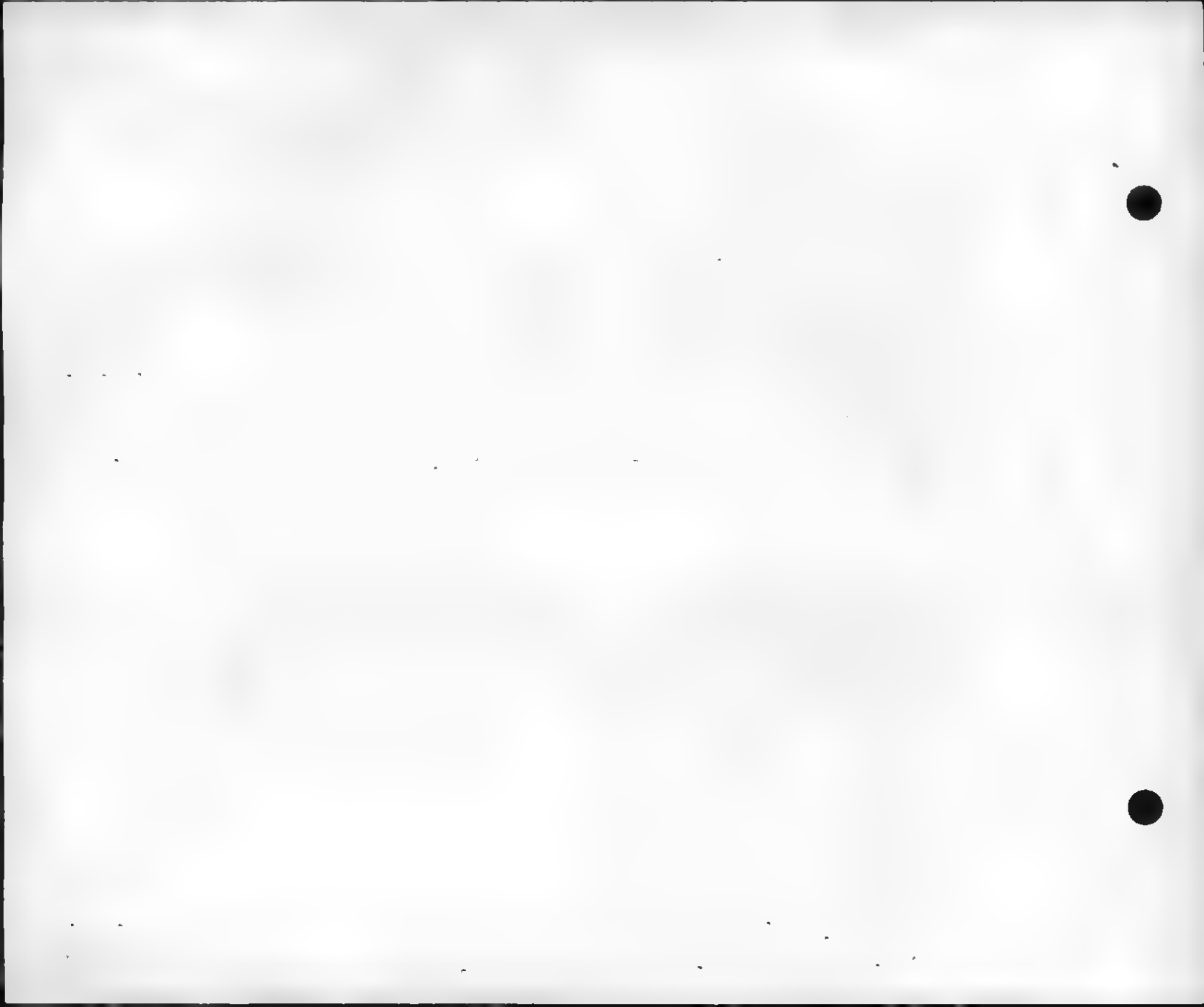
CERTIFICATE OF DEATH

1372

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 4 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 9405 AVENEL ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSP.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle JOHN Last SMITH		4. DATE OF DEATH Month DEC Day 27 Year 1967	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/95
9. AGE (In years last birthday) 72 yrs		10. UNDER 1 YEAR Months 1 Days 5 Hours 7 Min	11. UNDER 24 HRS Months 1 Days 5 Hours 7 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired agent		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue	11. BIRTHPLACE (County & State, or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Major D. Smith	
14. MOTHER'S MAIDEN NAME Sarah Singleton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-38-4440	
16. SOCIAL SECURITY NO. 215-38-4440		17. INFORMANT Eva L. Smith	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebral vascular accident DUE TO (b) Generalized arteriosclerosis DUE TO (c) Several years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 23, 1967 , to December 27, 1967 , that (I) (we) lost the deceased on December 26, 1967 , and that death occurred at 3:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Bennet A. Porter, Jr.		22b. DATE SIGNED December 27, 1967	
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr. M.D.		22d. ADDRESS 9301 Coleridge Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.	
25a. REC'D BY REGISTRAR Warner E. Humphrey, Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be returned for your files.

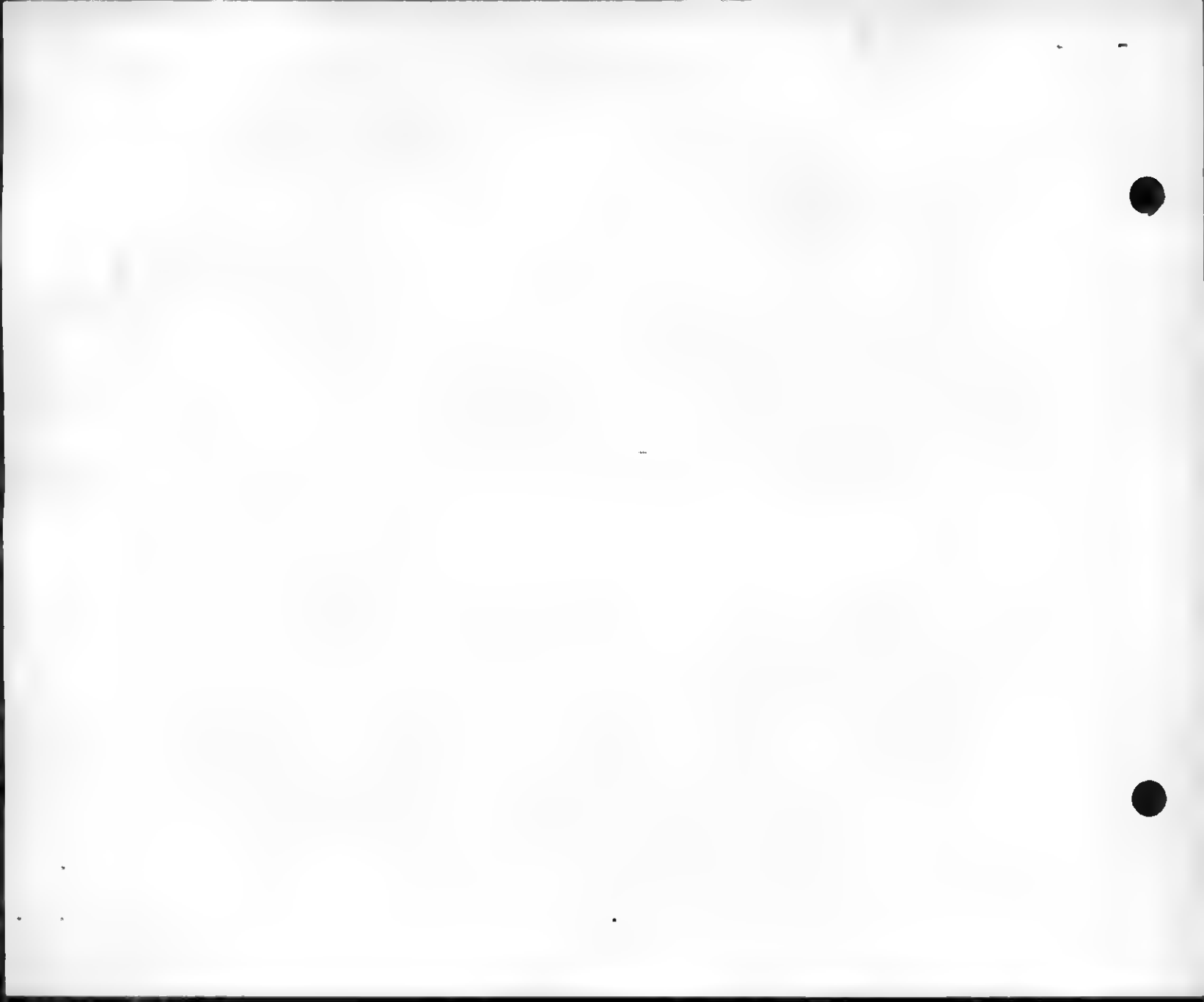
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17373

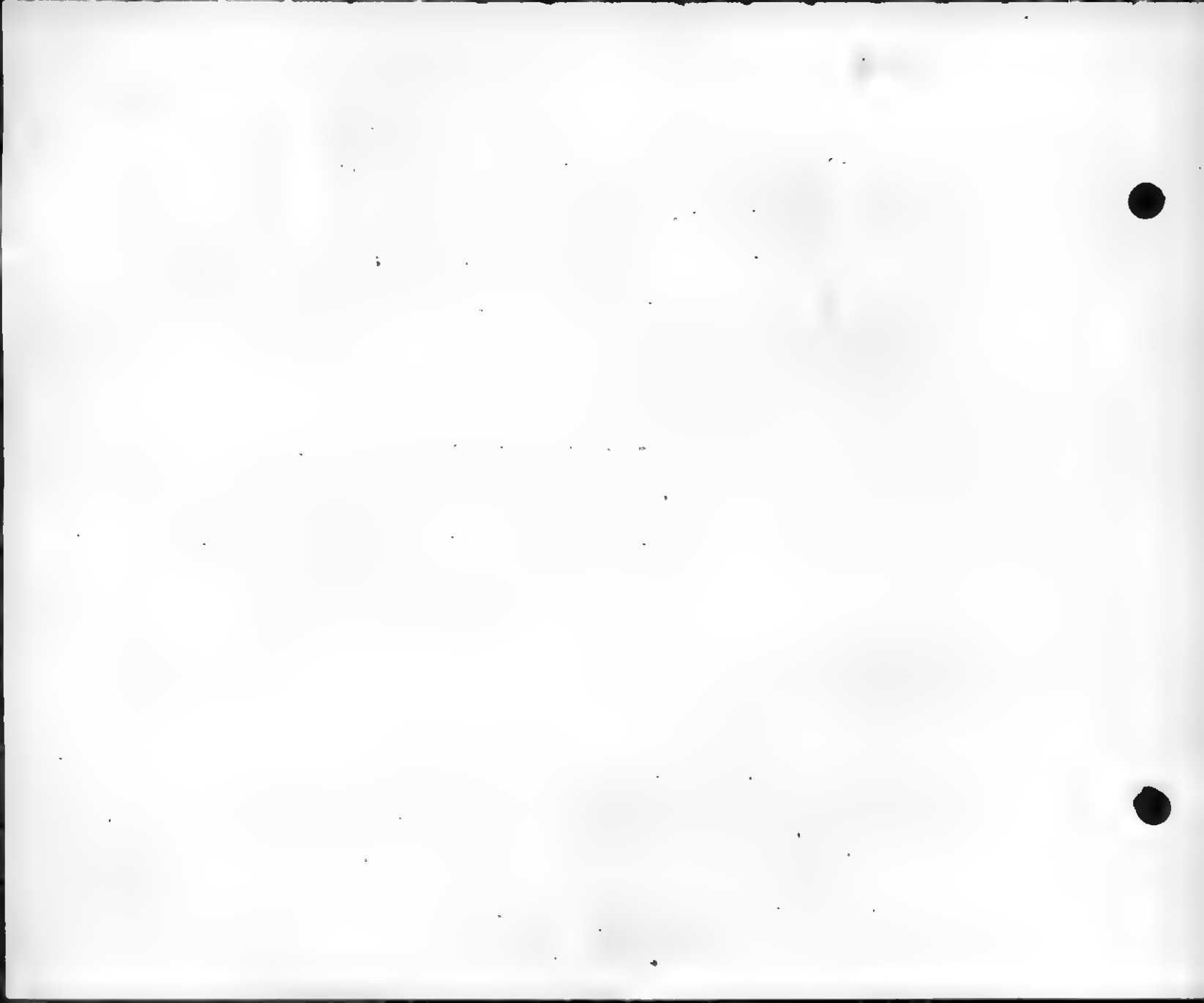
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D+A</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blen Echo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>6103 Princeton Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>Smith</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 11, 1904</u> 58
9 AGE (in years last birthday) <u>58</u>		10 UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11 BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Robert Edward Smith Dr.</u>		14 MOTHER'S MAIDEN NAME <u>Catherine E. Smith - wife</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>579-03-5133</u>	
17. INFORMANT <u>Catherine E. Smith - wife</u>		Address <u>add same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4241</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4241</u> DUE TO (c) <u>4241</u>		INTERVAL BETWEEN DEATH AND DEATH <u>4 hr.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>		
22. DATE SIGNED <u>12/18/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>	25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 11 months	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home 12325 New Hampshire Ave., Sil. Sp., Md.		d. STREET ADDRESS 37 Philadelphia Ave, Takoma Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE		First MIDDLE Last GOLDEN SPRINGMANN		4. DATE OF DEATH Month Day Year Dec. 22 19 67	
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-12-85		9. AGE (In years last birthday) 82 yrs.		10. IF FUNERARY 1 YEAR 11 MONTHS 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME CHARLES REANEY		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 218-56-8935-7		17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 17 YEARS (c)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Nov, 1960, to Dec, 1962, that (I) (we) last saw the deceased alive on 12-15 1962, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE Harry R. Wolf		M.D. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/22/1967	
22c. PHYSICIAN'S NAME (Type) H. R. WOLF		22d. ADDRESS 905 Shandon St Hyattsville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town or county) (State) Suitland BALD MD					
24. FUNERAL DIRECTOR J. H. Walters		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>30 yrs</u>		d. STREET ADDRESS <u>1908 Glen Allen Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1908 GLEN ALLEN AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>Stadler</u> Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Library</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henrich Stadler</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Eichenberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-46-6967</u>	
17. INFORMANT <u>Mrs R. Shuter</u> Address <u>1908 Glen Allen S.E. Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Edwards carcinoma metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>7 Pleural metastatic</u> (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2/15/67</u> <u>not known</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor growth under also ribs + not dry area</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/15/1966</u> to <u>12/4/1967</u> , that (I) (we) last saw the deceased alive on <u>11/28/1967</u> , and that death occurred at <u>130</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard T Morse</u> M.D.		22b. DATE SIGNED <u>12/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>		22d. ADDRESS <u>7630 Aronow Ave Takoma Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>McConellsburg, Penna.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11377

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b 15 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9706 Pisgah Rd. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DORAN (NAI) STARKEY		4. DATE OF DEATH Month Day Year 12 8 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-21
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min 10-11 Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLASSIFIED		10b. KIND OF BUSINESS OR IND. STRY DEPT. DEFENSE	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE B. STARKEY		14. MOTHER'S MAIDEN NAME HELEN PHILLIPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII AND KOREAN		16. SOCIAL SECURITY NO. 163-18-2438	
17. INFORMANT PETER EDIVAN		Address 2403 COOL SPRING RD. ADELPHI, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE (STROKE) TACI DUE TO CORONARY THROMBOSIS - MYOCARDIAL INFARCTION Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) 10-11 Hours DUE TO ARTERIO SCLEROTIC HEART DISEASE (c) CIRCA 5-6 YEARS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC CHOLELITHIASIS WITH CHOLELITHIASIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1966 to 12/8, 1967 that (I) (we) last saw the deceased alive on 12/8, 1967 , and that death occurred at 1:35 M, from causes and on the date stated above			
22a. SIGNATURE Lawrence D. Marcus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, MD.		22d. ADDRESS 1111 SPRING STREET, SILVER SPRING, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) RURAL		23b. DATE THEREOF 11 DEC. 1967	
23c. NAME OF CEMETERY OR CREMATORY GERMAN LUTHERAN CEMETERY		23d. LOCATION (City or town) (County) (State) MAHANOCY CITY PA.	
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME, 7400 GEORGIA AVE. NW, DC 20012		25a. REC'D BY REGISTRAR DEC 11 1967	
25b. REGISTRAR'S SIGNATURE Michael J. Judge			

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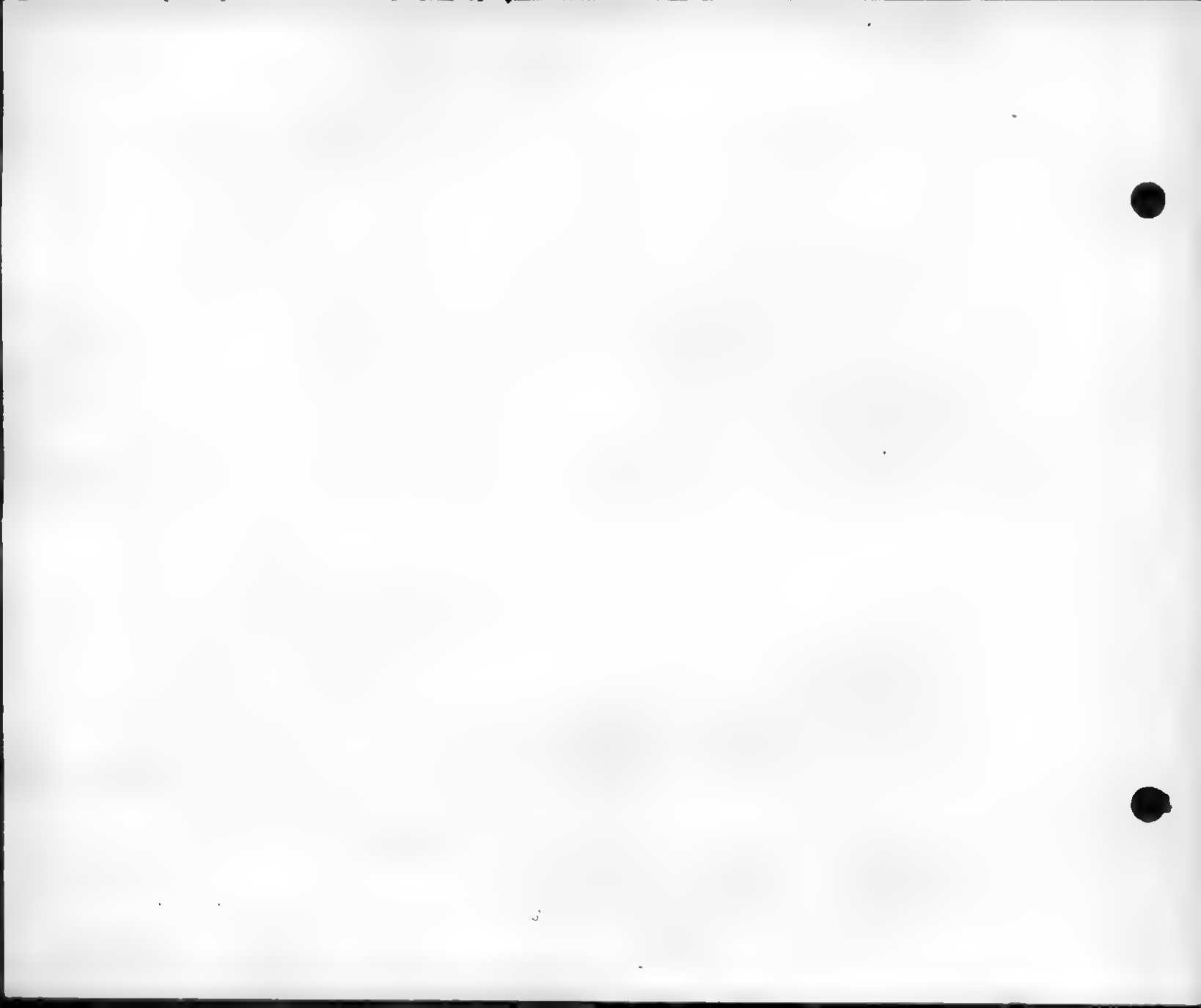
CERTIFICATE OF DEATH

1.378

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE M.D. C. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center		d. STREET ADDRESS 1028 Penn. Ave. NW	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle W. Last STEEVER		4. DATE OF DEATH Month 12 Day 31 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85 YRS
11. BIRTHPLACE (County & State, or foreign country) N/A		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alonzo M. L.		14. MOTHER'S MAIDEN NAME Jennie (Maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 325-09-3705	
17. INFORMANT Watson Andrews		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECENT FEBRILE RESPIRATORY DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 1962, to DEC 31 , 1962, that (I) (we) last saw the deceased alive on DEC 31 , 1967, and that death occurred at 2:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Edward A. Beeman M.D.		22b. DATE SIGNED DEC 31, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN		22d. ADDRESS 1015 SPRING ST. SILVER SPRING, MD.	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF Jan 5, 1968	23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Cincinnati, Ohio
24. FUNERAL DIRECTOR Murphy Funeral Home, Arlington, Virginia		25a. REC'D BY REGISTRAR DATE JAN 8 1968	25b. REGISTRAR'S SIGNATURE Richard Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 File # 3396 1/12/68

CERTIFICATE OF DEATH

17379

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAITHERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 6 WEST DEER PARK DRIVE	
3 NAME OF DECEASED (Type or print) First STEVEN Middle GIRL Last STEVENS		4 DATE OF DEATH Month December Day 28 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 28, 1967
9 AGE (In years last birthday) NB		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Minutes 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY NEWBORN	
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY-CITY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT STEVENS		14. MOTHER'S MAIDEN NAME BERTHA S. LINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEDICAL RECORDS-MONTGOMERY GEN. HOSP.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO Congenital abnormalities Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10h (c) 10h			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 10h			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 67 , to 12/28 , 19 67 , that (I) (we) last saw the deceased alive on 12/28 , 19 67 , and that death occurred at 11:45AM , from causes and on the date stated above.			
22a. SIGNATURE C. H. LIGON, M.D.		22b. DATE SIGNED 12-29-67	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M.D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-30-67	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City or Town) (County) (State) Faithersburg, Mont. Md.
24. FUNERAL DIRECTOR Ernest C. Gortner		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE James Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

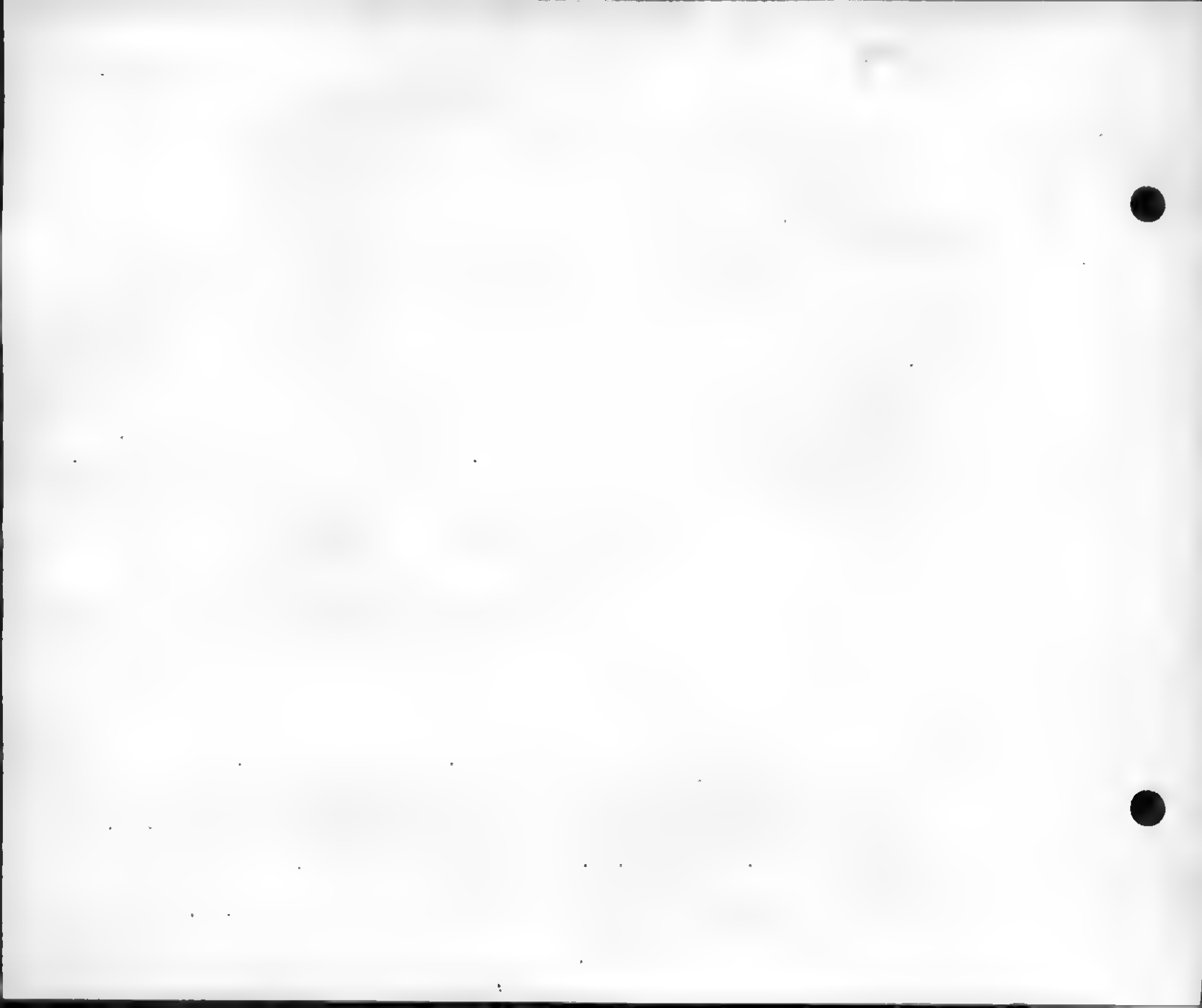
CERTIFICATE OF DEATH

11380

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunbar</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>308 1/2 11th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Van Cleve</u> Middle <u>STILTNER</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 67</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1913</u>		9. AGE (in years last birthday) <u>54</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Stiltner</u>				14. MOTHER'S MAIDEN NAME <u>Grace Monohan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 1931-1953</u>		16. SOCIAL SECURITY NO. <u>233-56-9592</u>		17. INFORMANT <u>Dunbar</u> Address <u>W. Va.</u> <u>Mrs. Virginia Stiltner, 308 1/2 11th St.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Encephalomalacia of left temporal parietal area</u> <u>443X</u> DUE TO <u>massive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>10 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>Dec. 6</u> , 19 <u>67</u> , to <u>Dec. 10</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Dec. 10</u> , 19 <u>67</u> , and that death occurred at <u>145 PM</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Charles S. Reeves</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Dec. 11, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles S. Reeves, M. D.</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roselawn Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Princeton, W. Virginia</u>			
24. FUNERAL DIRECTOR <u>Falls Church</u> ADDRESS <u>Funeral Home, 1102 West Broad St., Falls Church</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEC 14 1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1.381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> DISTRICT <u>Col'd</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>22 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e STREET ADDRESS <u>1660 Lanier Place - N.W.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Irene E. Stinemetz</u>		4 DATE OF DEATH <u>December 16, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 18, 1889</u> 78 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auditor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>G. H. O.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel W Stinemetz</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Beth Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>William H. Alexander</u>		Address <u>1660 Lanier Pl. N.W.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & Long Heart failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>accro</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Nov. 20</u> , 19 <u>67</u> , to <u>Dec. 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15</u> , 19 <u>67</u> , and that death occurred at <u>A</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Russell C Bufalino</u> M.D.		22b DATE SIGNED <u>Dec 16, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Russell C Bufalino M.D.</u>		22d ADDRESS <u>University Blvd W. St. Mo.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-19-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a REC'D BY REGISTRAR <u>DEC 26 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

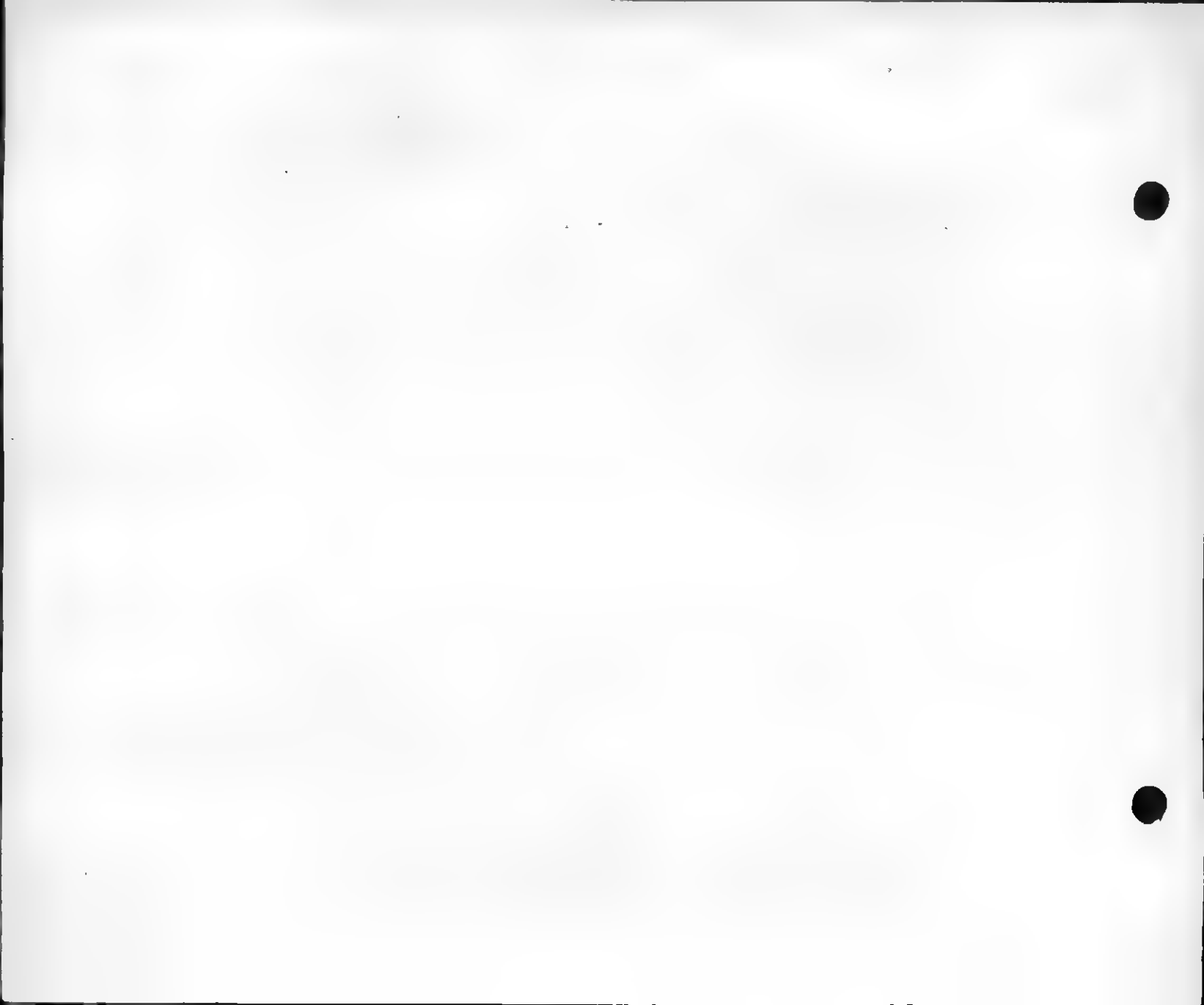


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Olney</u>			c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Gen. Hosp.</u>					d. STREET ADDRESS <u>17715 Caswell Rd.</u>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PEARL MARIE STONER</u>					4. DATE OF DEATH Month <u>DEC.</u> Day <u>16</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/25/18</u>		9. AGE (In years lost birthday) <u>49</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Calvin Dunfee</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>7528 Sweet Briar College Park, Md.</u> <u>Twila Stoner Hirlinger</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to smoke inhalation during</u> <u>416.0</u> DUE TO (b) <u>house fire</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Deceased asleep when house caught fire</u>					
20c. TIME OF INJURY Month, Day, Year <u>12.30 a.m.</u> <u>12-16</u> <u>1967</u>				20d. NATURE OF INJURY While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>W. W. Chambers, Inc. - Silver Spring, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>12/19/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETARY</u>		23d. LOCATION (City or town) (County) (State) <u>CILMAR PARK PRINCE GEORGE MD.</u>			
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS, INC. - SILVER SPRING, MD</u>					25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		

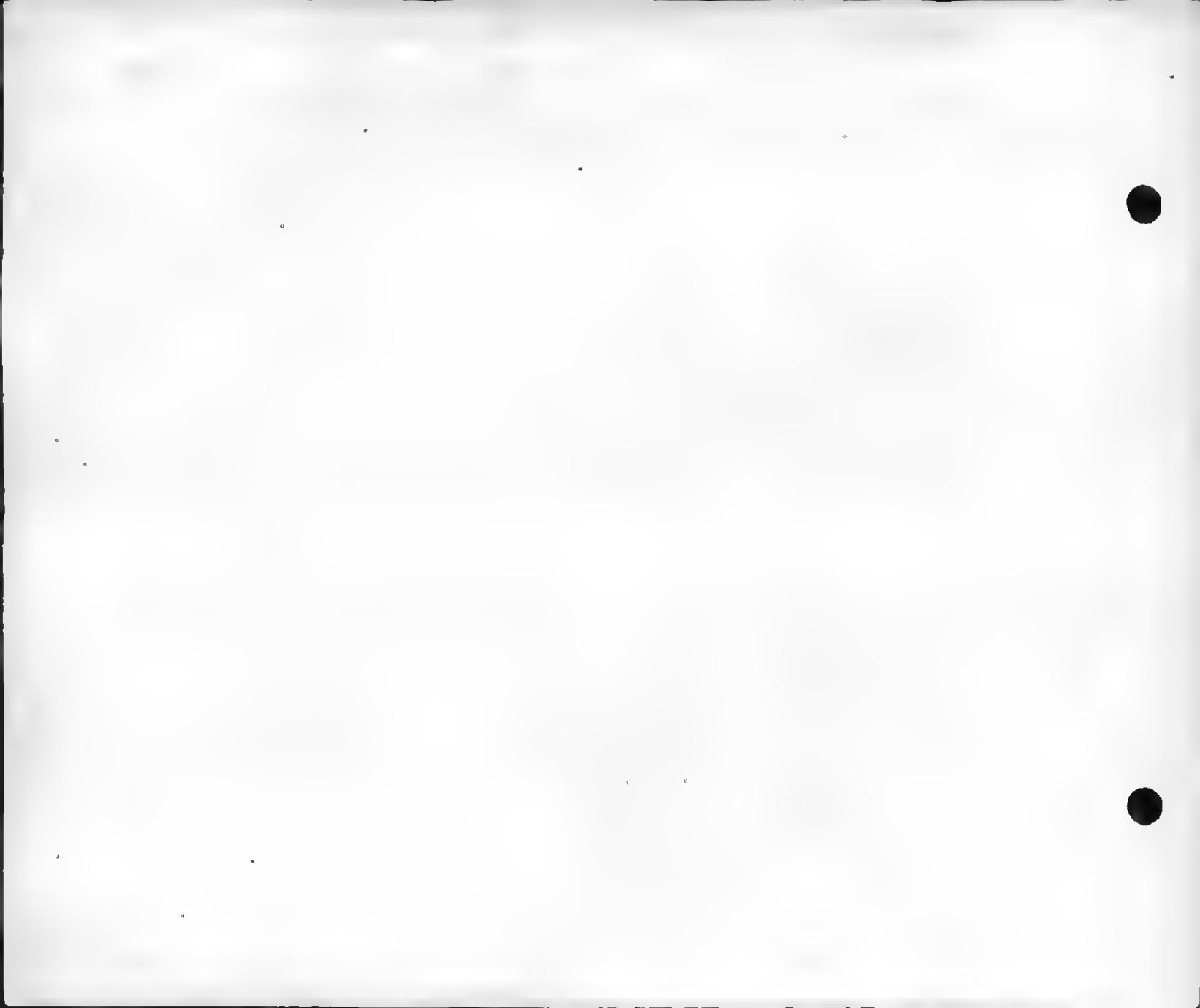


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17382					17383				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Mont. MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Md. b. COUNTY Mont.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 3 Mos. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home					d. STREET ADDRESS 4322 Leland St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lallie First Middle Last A Street					4. DATE OF DEATH Month 12 Day 27 Year 19 67				
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-27-75		9. AGE (In years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Alabama			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME John Abergronbie					14. MOTHER'S MAIDEN NAME Laura Martin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-1774		17. INFORMANT Laura Jackson			4322 Leland St. Bethesda, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arterio sclerotic Cardiac vascular disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute viral upper respiratory infection								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to Dec. 27, 1967 , that (I) (we) last saw the deceased alive on Dec. 26, 1967 , and that death occurred at 5:05A AM, from causes and on the date stated above.									
22a. SIGNATURE Alfred S. Norton M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/67		
22c. PHYSICIAN'S NAME (Type) Dr. Alfred Norton					22d. ADDRESS 7710 Dwight Ave., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-27-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City or town) (County) (State) Suitland Md.		
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. REC'D BY REGISTRAR Bethesda Md.		25b. REGISTRAR'S SIGNATURE DEC 29 1967		



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1,384

1. DECEASED-NAME (Type or print) <i>Father</i> First Middle Last			2a. DATE OF DEATH <i>Dec</i> Month <i>23</i> Day <i>1967</i> Year			2b. HOUR <i>5:30 PM</i> M			
3. SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>APRIL, 1864</i>		6. AGE (In years last birthday) <i>103</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bethesda Silver Spring Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>H.W.</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4501 Conn. Ave. N.W.</i>	
14. FATHER'S NAME First Middle Last <i>A BRAHAM H. GOLDEN</i>				15. MOTHER'S M.A.DEN NAME First Middle Last <i>UNKNOWN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>PHILIP SURES 4740 CONN. AVE. N.W.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-Pneumonia</i> <i>7110</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arterio Sclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> , 19 <i>67</i> , to <i>12/23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/23</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Samuel Dessoff</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/23/67</i>			
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL DESSOFF</i>		22e. ADDRESS <i>1302-18 ST. N.W. WASH. D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/26/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Mem. Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>			
24. FUNERAL DIRECTOR <i>B. DANZANSKY & SONS</i>				ADDRESS <i>3501 14th St. N.W.</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

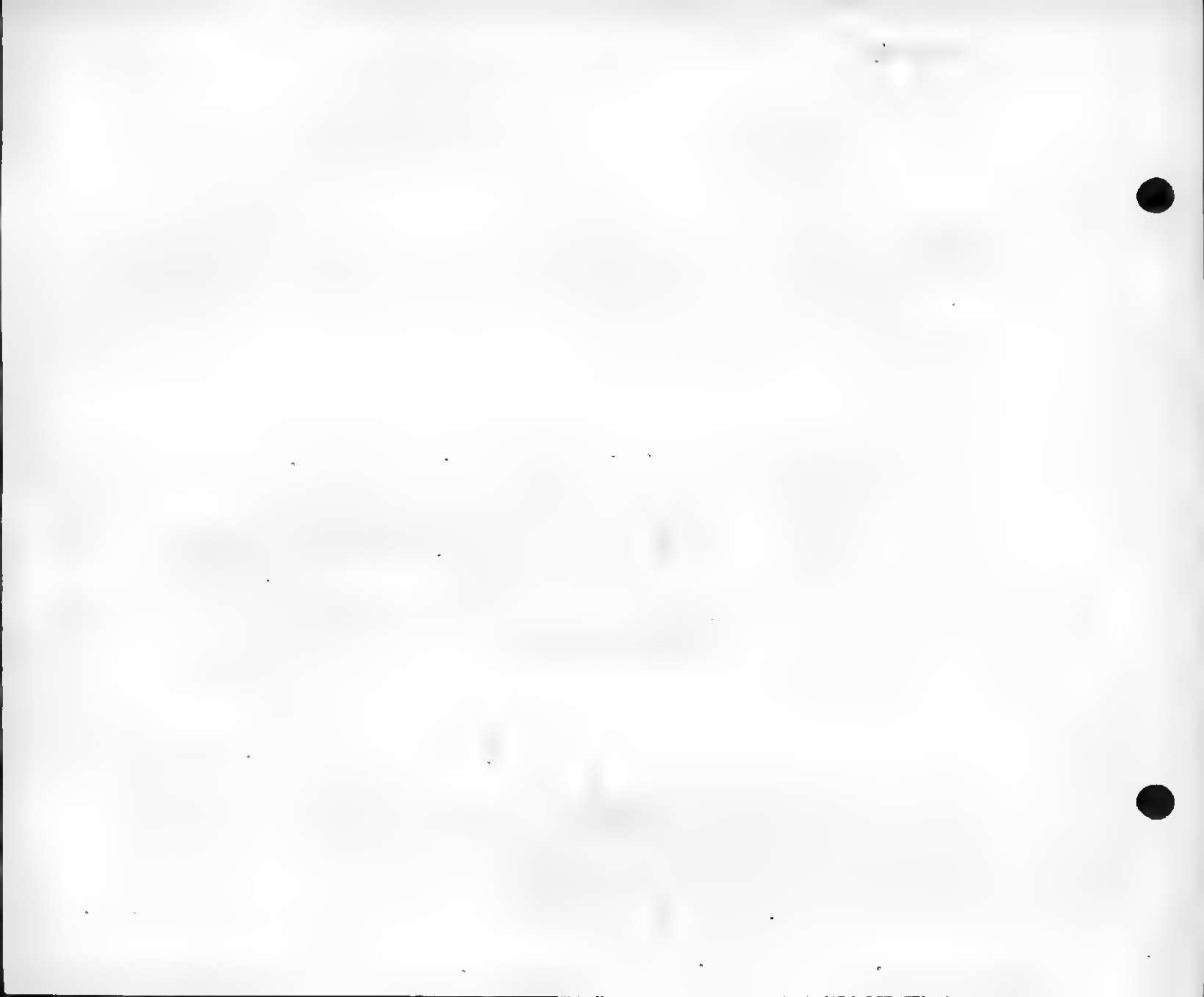
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17385

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>North Forestville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Forestville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u> <u>2325 New Hampshire Ave.</u>				STREET ADDRESS <u>3418 83rd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>E.</u> Middle <u>Tapscott</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-1894</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. Transit Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Driver</u>		11. BIRTHPLACE (County & State or foreign country) <u>Clark County, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>James E. Tapscott</u>			
14. MOTHER'S MAIDEN NAME <u>Henrietta Stickles</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>578-10-6718</u>		17. INFORMANT <u>Mary B. Tapscott</u> <u>3418 83rd Avenue</u> <u>N. Forestville, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Chronic Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> DUE TO <u>5 yrs</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Cerebrovascular</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>17 Dec.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> 19 <u>67</u> , and that death occurred at <u>6P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William Harvey</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>17 Dec '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William Harvey</u>				22d. ADDRESS <u>2121 Penn. Ave NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		23b. DATE THEREOF <u>Dec. 20 - 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Clark E. Tapscott</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>		REGISTRAR'S SIGNATURE <u>Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

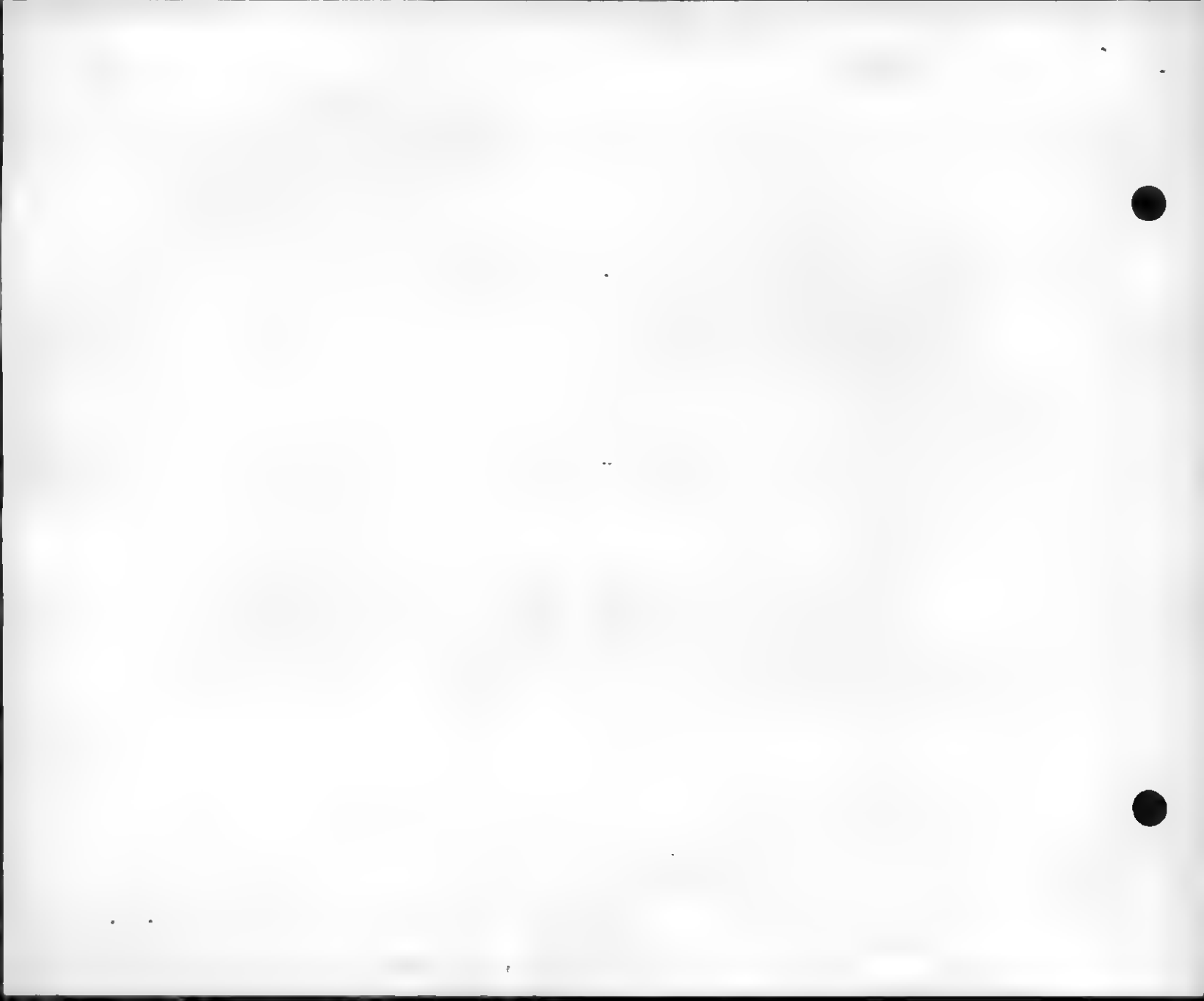
CERTIFICATE OF DEATH

17386

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10201 Grosvenor Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-01</u>
9. AGE (in years lost birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-Organist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Copplestone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-62-5429</u>	
17. INFORMANT <u>Rev. 10 Donald Taylor - SON</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>194X METASTATIC CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF THYROID</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>3 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>66</u> , to <u>DEC</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>DEC 26</u> , 19 <u>67</u> , and that death occurred at <u>1:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Madeloff et al.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MADELOFF, MICHAELS</u>		22d. ADDRESS <u>504 Elderwood Rd.</u>	
23a. BURIAL CREMATION, <u>Burial</u> (Specify)	23b. DATE THEREOF <u>12/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17386

17387

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day 1 1/2 hr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN + Hosp.</u>		e. STREET ADDRESS <u>7458 SAN JUAN DR.</u>	
3 NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Upton B</u> Last <u>Thompson</u>		4 DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-17-37</u>
9 AGE (In years last birthday) <u>30</u> yrs.		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11 UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phico Ford Corp.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Upton Thompson</u>		14. MOTHER'S MAIDEN NAME <u>MIRIAM DRAVY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes U.S. Navy '64</u>		16. SOCIAL SECURITY NO. <u>219-34-9257</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>401</u> DUE TO (b) <u>LYMPHO-SARCOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>pan cytopenia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> , 19 <u>67</u> , and that death occurred at <u>6:20</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>W. Clarke Mattingley</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1201 N.W. 2nd St., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Dec. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CHURCH CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HOLLYWOOD, ST. MARY'S, MD.</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>	
ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Md. Medical Examiner - 12/16/67 HTE

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HAVEN c. LENGTH OF STAY IN b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HAVEN d. STREET ADDRESS (D.C. 20016) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle LARDNER Last TOBIN		4. DATE OF DEATH Month DEC. Day 7 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1883
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) NILES MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY LARDNER		14. MOTHER'S MAIDEN NAME LENA B. PHILLIPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 081-01-6807	
17. INFORMANT (daughter) ANNE WILLCOX		Address 5310 WRILEY RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) — (c) — DUE TO (b) — (c) —			INTERVAL BETWEEN ONSET AND DEATH ± 30 min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASTHMA - ARTERIOSCLEROTIC HEART DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) — (County) — (State) —
21. I certify that (1) (this hospital) attended the deceased from FEB , 1967, to DEC , 1967, that (2) (we) last saw the deceased alive on AUG 2 , 1967, and that death occurred at 6:15 AM , from causes and on the date stated above			
22a. SIGNATURE Henry D. Ecker		22b. DATES SIGNED MD 12/7/67 MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) HENRY D. ECKER MD		22d. ADDRESS 916-19th St. N.W. - DC 20006	
23a. BURIAL, CREMATION, REMOVAL REMOVAL	23b. DATE THEREOF 12/8/1967	23c. NAME OF CEMETERY OR CREMATORY Zion Episcopal Church Cem. Douglaston, L.I. N.Y.	
23d. LOCATION (City or Town) — (County) — (State) —		24. FUNERAL DIRECTOR Joseph Hausman 5130 Washington Co. Rd. Wash. D.C.	
25a. REC'D BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE —	
DATE DEC 15 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

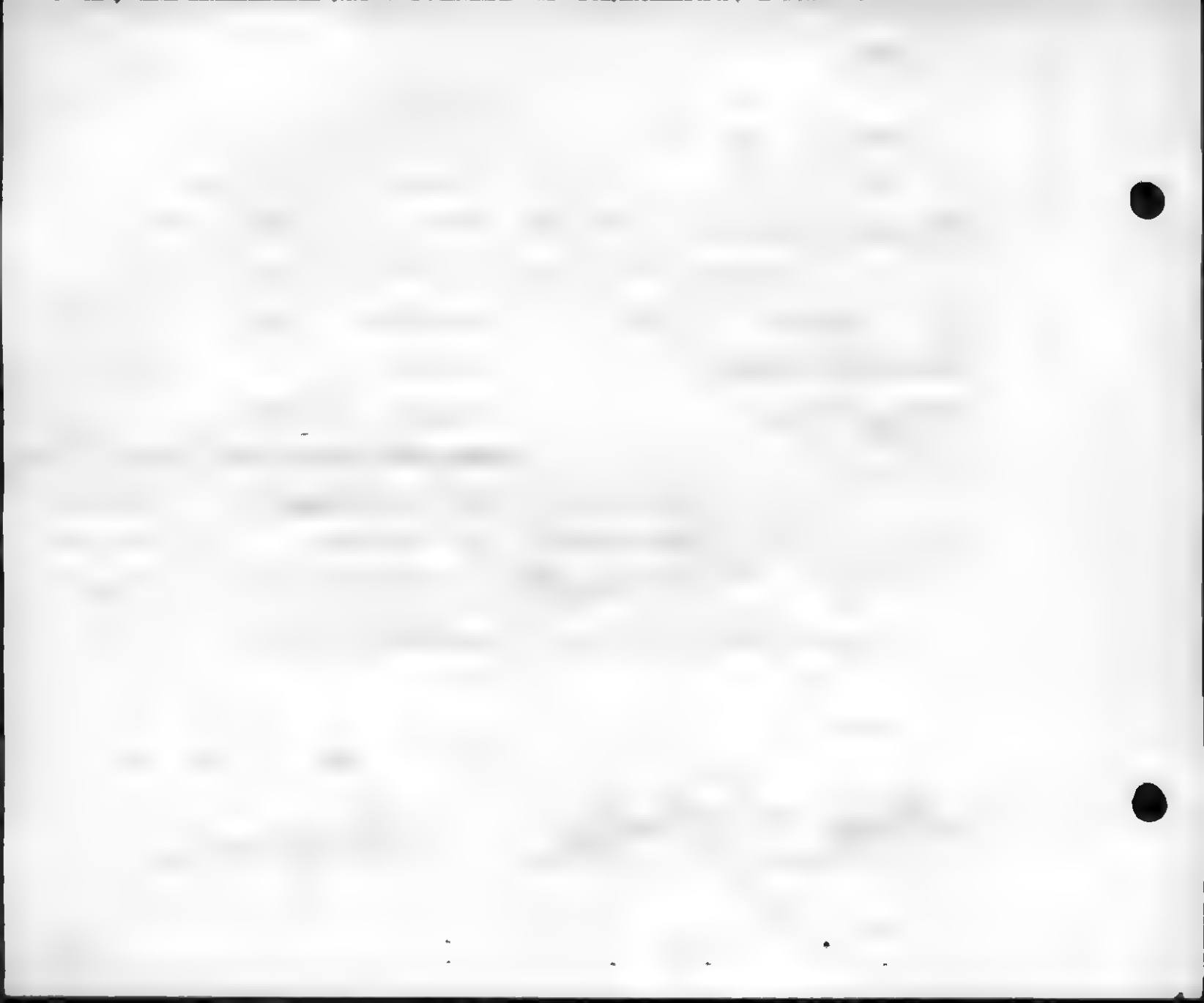
CERTIFICATE OF DEATH

17389

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>25 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Martha Frances Todd</u>				4. DATE OF DEATH <u>December 15 19 67</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-1-85</u>	9 AGE (In years lost birthday) <u>82</u> yrs.	10 UNDER 1 YEAR Months Days	10 UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		
13. FATHER'S NAME <u>Henry Riffin</u>			14. MOTHER'S MAIDEN NAME <u>Emily Price</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>517-427632</u>		17. INFORMANT <u>Martha Todd-Chester</u> <u>Washington Sanitarium & Hospital Records</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebro-sclerosis</u> DUE TO (c) <u>Rheumatoid Arthritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year <u>Hour a.m. p.m. 19</u>			20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 19 57</u> to <u>Dec 15, 19 67</u> and that (I) (we) last saw the deceased alive on <u>Dec 14, 19 67</u> and that death occurred at <u>M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>George L. Ball</u>			22b. DATE SIGNED <u>DEC 15, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/18 1967</u>			23b. DA <u>12/18 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		
23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>			24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			25c. ADDRESS <u>Silver Spg. Md.</u>				



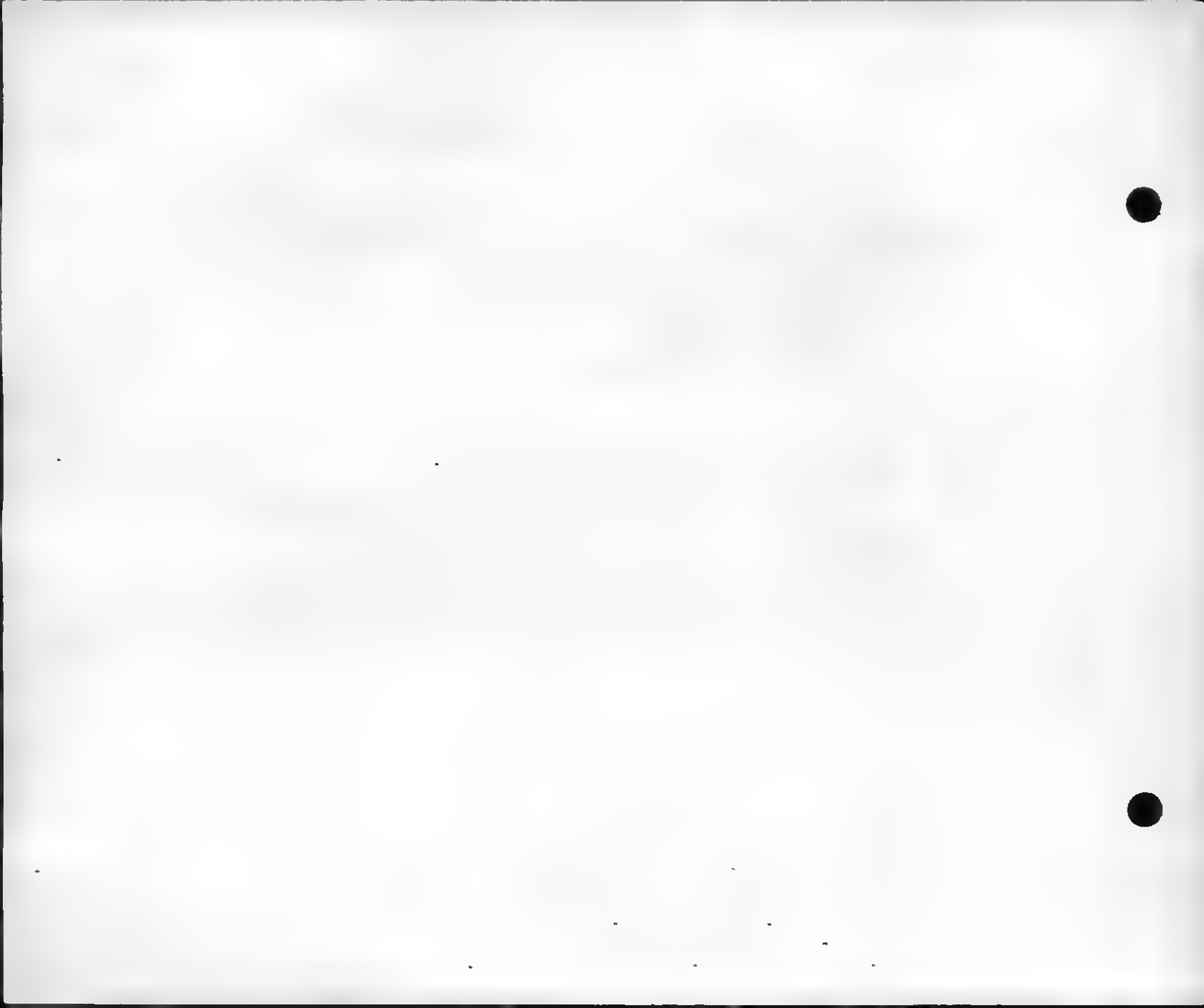
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17390

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>5 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12515 Georgia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jane Francis Tophill</u> First Middle Last			4. DATE OF DEATH <u>Dec 12 1967</u> Month Day Year				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/06</u>	9. AGE (n years last birthday) <u>61</u>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Bean</u>				
14. MOTHER'S MAIDEN NAME <u>Catherine Kerr</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO <u>No</u>			17. INFORMANT <u>Lionel A. Tophill, Sr.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Saddle Embolus Due To Peritonitis</u> 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multiple Peritoneal Abscesses</u> DUE TO (c) <u>Perforated Carcinoma Of Sigmoid Colon (1 Week)</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>67</u> , to <u>12/12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/11</u> , 19 <u>67</u> , and that death occurred at <u>11:25 a.m.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Harold S. Tidler</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <u>12/12/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Harold S. Tidler</u>				22d. ADDRESS <u>9402 Venton Street, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Forest Glen</u>			
23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>		25a. RECD BY REGISTRAR <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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17210

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>5134 Alberta Avenue 21236</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Philip</u> Last <u>Trumpe</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 March 1924</u>		
9. AGE (In years last birthday) <u>43</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Raymond Trumpe</u>				
14. MOTHER'S MAIDEN NAME <u>Cyvilla Myers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes 1942-1946</u>				
16. SOCIAL SECURITY NO <u>217-16-8500</u>				17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Endogenous Hyperlipemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 Years</u> <u>43 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 5, 1967</u> to <u>December 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 22, 1967</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Ferid Murad</u>				MD ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>23 December 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Ferid Murad, MD.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-27-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>				ADDRESS <u>740 1/2 Blair Road</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17392

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 3306 14th AVENUE	
3 NAME OF DECEASED (Type or print) First MORTON Middle UTERMAN Last UTERMAN		4. DATE OF DEATH Month DECEMBER Day 13 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-15-1911
9 AGE (In years last birthday) 56 yrs		10. UNDER 1 YEAR Months 5 Days 13 Hours 13 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11 BIRTHPLACE (County & State, or foreign country) NEW YORK		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME ISAAC UTERMAN		14 MOTHER'S MAIDEN NAME ANNA SICKLICK	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 111-09-9888	
17. INFORMANT Diana Bengis		Address 658 188th Street New York, New York	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 437.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure, acute DUE TO (c) Arteriosclerotic cardio vascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 min. 1 hr. 5 Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 67 to 12/13 , 19 67 , that (I) (we) last saw the deceased alive on 12/13 , 19 67 , and that death occurred at 10 AM , from causes and on the date stated above.			
22a. SIGNATURE Myron L. Lenkin		22b. DATE SIGNED 12-13-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-17-1967	23c NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church Va.
24. FUNERAL DIRECTOR Goldoor Funeral Home		25a. REC'D BY REGISTRAR DEC 20 1967	
ADDRESS 4217 9th Street N. W.		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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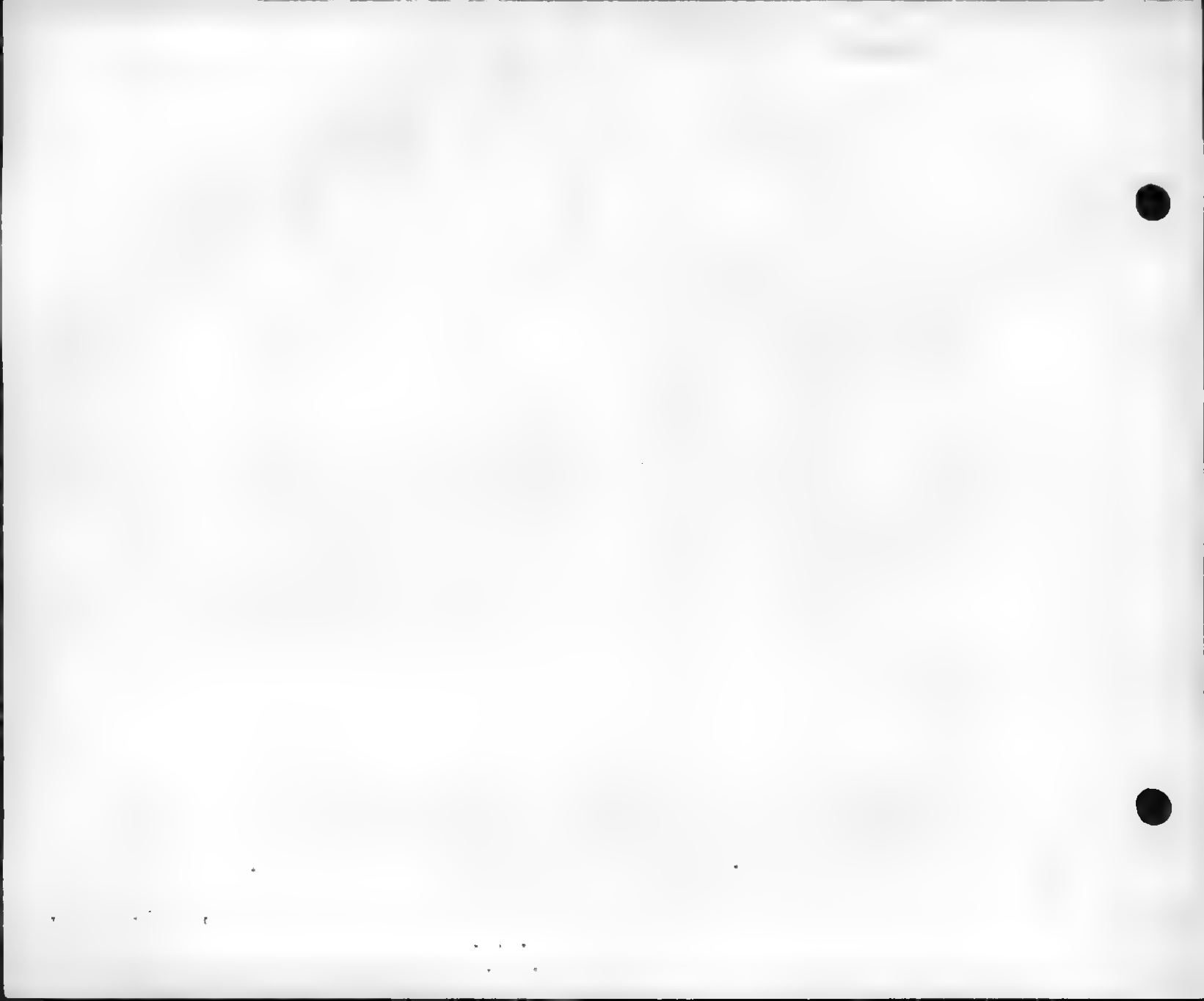
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17393

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY in 1b <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>8704 Irvington Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Ethel Mae Urwick</u>		4 DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u> <u>3/5/1894</u>
9a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>73</u> Months Days Hours Min.
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <u>Washington - DC</u>
13. FATHER'S NAME <u>Charles Lippett</u>		14. MOTHER'S MAIDEN NAME <u>Genvie unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>213-48-2715</u>	
17 INFORMANT <u>Mrs. Helen - Abene</u> (Daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarct</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 weeks</u> <u>YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour to m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>67</u> , to <u>12/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>67</u> , and that death occurred at <u>5:55 PM</u> from causes and on the date stated above.			
22a SIGNATURE <u>Sidney J. Malawer</u>		22b DATE SIGNED <u>12/8/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Sidney J. Malawer</u>		22d ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12/11/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>	23d LOCATION (City or Town) (County) (State) <u>Bladensburg, (P.G.Co) Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>	
ADDRESS <u>Wash. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and 6 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

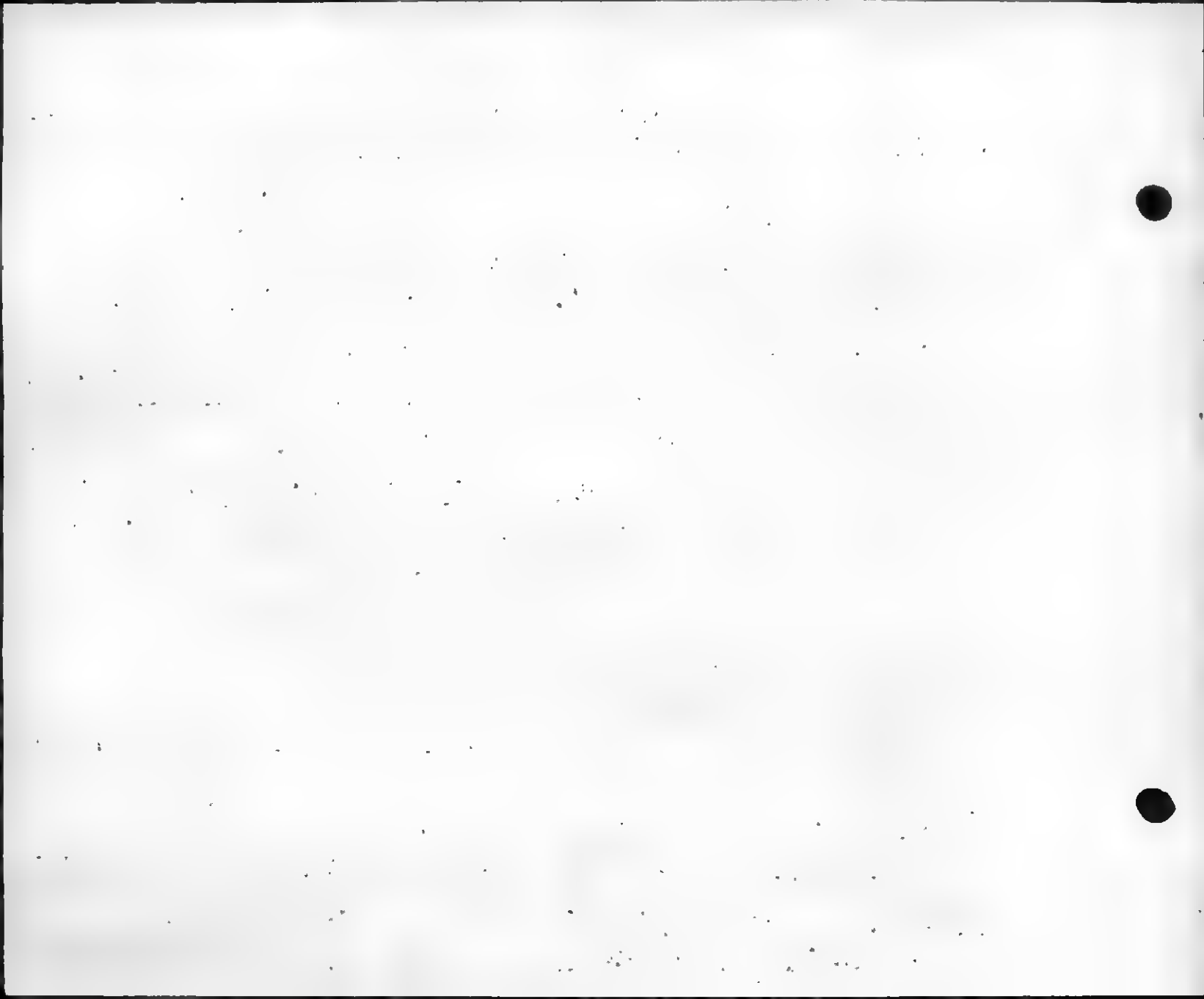
VR A 54
30th REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17394

1. DECEASED-NAME (Type or print) RINZE E. VANDERVEEN			2a. DATE OF DEATH Month Dec Day 28 Year 1967			2b. HOUR 5:30 P.M.			
3. SEX M		4. RACE White		5. DATE OF BIRTH May 29-1915		6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a. BIRTHPLACE (State or foreign country) Holland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 22 W. Summit		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 22 W. Summit		12b. KIND OF BUSINESS OR INDUSTRY 12 W. Summit			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND		13b. COUNTY Gaithersburg		13c. CITY OR TOWN Gaithersburg		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 22 W. Summit	
14. FATHER'S NAME First Middle Last Rinze A. VanderVeen			15. MOTHER'S MAIDEN NAME First Middle Last Martha K. Elhome						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO. 113-07-0959		17. INFORMANT Margaretha E. VanderVeen		Address Gaithersburg 22 W. Summit Av			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF ADIPOSCLEROSIS PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN YEARS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 570 W. FREDERICK Gaithersburg Md.					
22a. I certify that (I) (this hospital) attended the deceased from January 1967 , to Dec 28, 1967 , that (I) (we) lost saw the deceased alive on Dec 28, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE STEVEN C. GARTNER MD				22c. DATE SIGNED Dec 28 1967		22d. PHYSICIAN'S NAME (Type) Ernest C. Gartner			
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE 12-30-67		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.			
24. FUNERAL DIRECTOR Ernest C. Gartner				25a. REC'D BY REGISTRAR DATE JA 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Filed 1/2/68

CERTIFICATE OF DEATH

17395

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist/ of Col. b. COUNTY - - - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4000 Massachusetts Ave. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle E. VENCILL Last 4. DATE OF DEATH Month December Day 21 Year 1967		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1-6-1878 9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - - - 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Cass Morris 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - 16. SOCIAL SECURITY NO. - - - 17. INFORMANT Genevieve Vencill- See Item No. 2 Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident - Thrombosis DUE TO (b) Generalized Cerebrovascular non/vascular DUE TO (c) - - - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None 20c. TIME OF INJURY Month, Day, Year Hour None a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None 20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from 12/13 , 19 67 , to present , that (2) (we) last saw the deceased alive on 12/20 19 67 , and that death occurred at 11:15 AM from causes and on the date stated above. 22a. SIGNATURE John B. Umhan 22b. DATE SIGNED 12/22/67 22c. PHYSICIAN'S NAME (Type) JOHN B. UMHAN MD 22d. ADDRESS 8805 Conn. Ave. Chevy Chase	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 12-22-1967 23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery 23d. LOCATION (City or Town) (County) (State) Silver City, N.M.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 130 Wisc. Ave. N.W. Wash. D.C. 25a. REC'D BY REGISTRAR DATE DEC 28 1967 25b. REGISTRAR'S SIGNATURE - - -	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17396

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>1 da.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>5910 Cherrywood Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ENRIQUE</u> Middle <u>MIRALLES</u> Last <u>VERA</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 17, 1967</u> 9. AGE (In years last birthday) <u>1 day</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ENRIQUE MARTINEZ VERA</u>		14. MOTHER'S MAIDEN NAME <u>LILIAN MIRALLES SILVA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>ENRIQUE VERA</u> Address <u>BRENEBOLT, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776K</u> DUE TO <u>immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>6/14/67</u> to <u>6/18/67</u> , that (1) (we) last saw the deceased alive on <u>12/18</u> 19 <u>67</u> , and that death occurred at <u>6:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M. J. Moore</u>		22b. DATE SIGNED <u>12-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARLIP MOORE</u>		22d. ADDRESS <u>1003 Spring 14</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/23/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

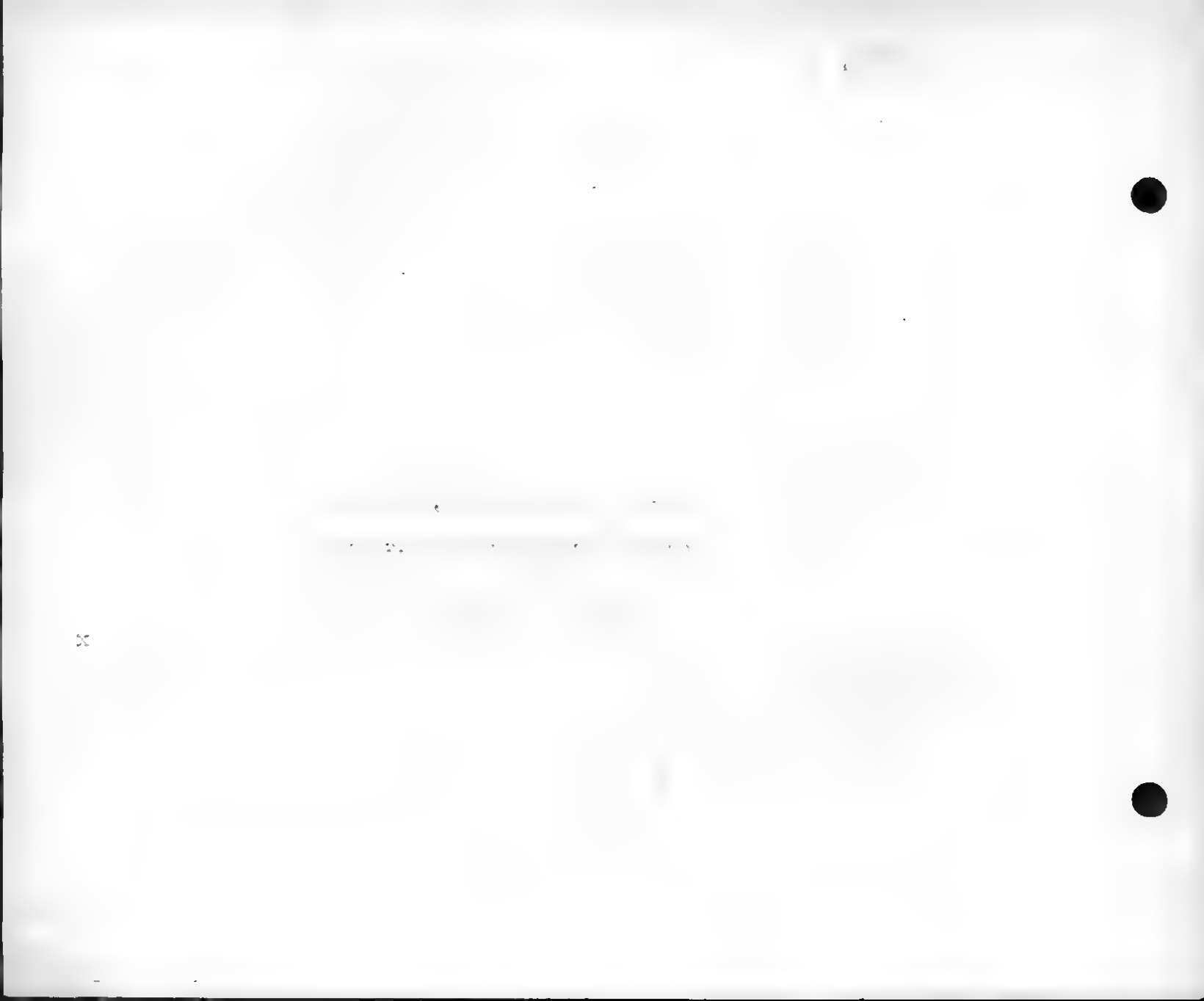
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>3606 DUNDREE DR</u> <u>10002 Maryland Drive</u>	
3 NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>Virginia</u> Middle <u>WAGNER</u> Last		4 DATE OF DEATH <u>Dec</u> Month <u>15</u> Day <u>1967</u> Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 1, 1902</u> 65 yrs.
9 AGE (In years last birthday) <u>65</u>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11 BIRTHPLACE (State or foreign country) <u>Mineral, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>HARRY JOHNSON</u>		14 MOTHER'S MAIDEN NAME <u>ANGELINA PATERSON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>LOUIS H. CROCE</u> Address <u>Dundee Dr</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary insufficiency, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, severe</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/15/67</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12/18/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>	23d LOCATION (City or town) (County) (State) <u>BLADENSBURG, PG. MD.</u>
24 FUNERAL DIRECTOR <u>JOSEPH GAWLER & SONS 5130 Wisconsin Ave</u>		25a REC'D BY REGISTRAR <u>DEC 26 1967</u>	
ADDRESS <u>WASH. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>J. W. Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17398

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery.</u> MARYLAND.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. LENGTH OF STAY IN 1b <u>6 Mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Topaz Home, 4400 East West Hwy.</u>		e. STREET ADDRESS <u>4400 East West Hwy.</u>	
3 NAME OF DECEASED (Type or print) First <u>Walter</u> (NMI) Middle <u>Wallace.</u> Last <u>Wallace.</u>		4 DATE OF DEATH Month <u>Dec-</u> Day <u>10</u> Year <u>19 67</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 3 1905</u>
9 AGE (in years last birthday) <u>62</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics Engr</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Philippines.</u>	
13. FATHER'S NAME <u>John. Walezykowski</u>		14. MOTHER'S MAIDEN NAME <u>Marcela. Martinis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of serv. ca.) <u>Yes</u> <u>WW II</u>		16 SOCIAL SECURITY NO <u>379-40-2905</u>	
17 INFORMANT <u>Wife</u>		Address <u>Metta R. Wallace Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency, Acute.</u> DUE TO (b) <u>Cardiovascular Disease -</u> CONDITIONS (if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		22. DATE SIGNED <u>12/10/67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF <u>12-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>	25b. REGISTRAR SIGNATURE <u>Michael Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

D.M.G. DECEASED SHALL NOTIFIED & APPROVED

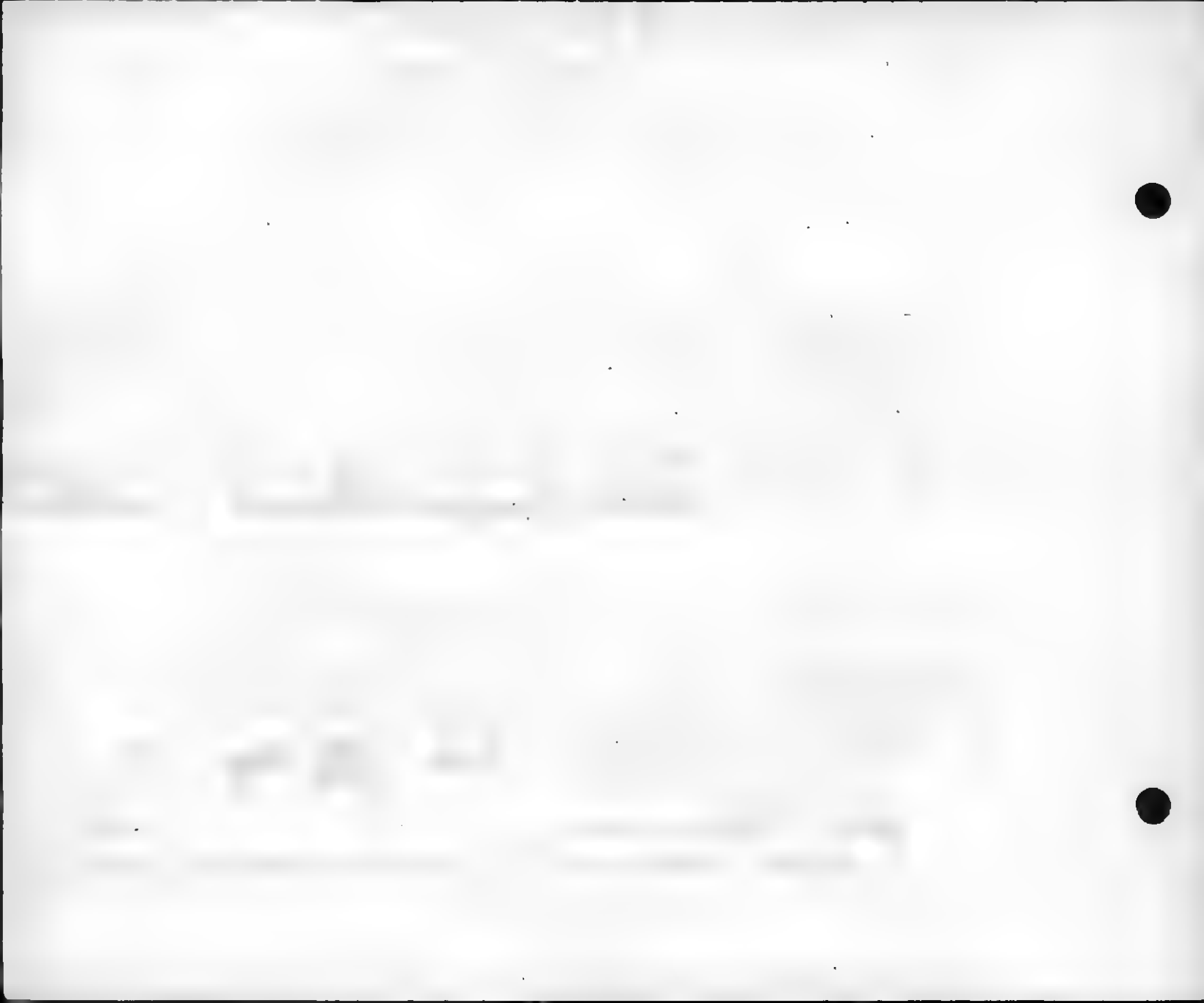
1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17399

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10401 GROSVENOR PLACE</u>		d. STREET ADDRESS <u>10401 GROSVENOR PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>WEINBERG</u> Last <u>WEINBERG</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1907</u>
9. AGE, (n years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF-EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ART DEALER</u>	
11. BIRTHPLACE (County & State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISIDORE WEINBERG</u>		14. MOTHER'S MAIDEN NAME <u>ANNA REINANDEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS BEN WEINBERG</u>		Address <u>SAME AS 2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>48</u> , to <u>Dec 17</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>12-7-</u> 19 <u>67</u> , and that death occurred at <u>9:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Abramson</u> M.D.		22b. DATE SIGNED <u>12-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT ABRAMSON, M.D.</u>		22d. ADDRESS <u>1250 - Conn Ave NW - Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>12-20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW MOUNTFLORE CEM. PINEAUX, L.I. NY</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME 4217 9TH ST. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17400

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) <input checked="" type="checkbox"/> a STATE <u>VIRGINIA</u> b COUNTY <u>ARLINGTON</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c LENGTH OF STAY IN 1b <u>10-28-67</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>T.</u> Last <u>Whaley</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-25-1909</u>
9. AGE (In years last birthday) <u>58</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country) <u>WASHINGTON DC</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES KAISER</u>		14. MOTHER'S MAIDEN NAME <u>CLARA ANN DEITRICH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>557-03-7747</u>	
17 INFORMANT <u>MARGARET M PEUNTON</u>		Address <u>Kensington, Md. 10225 KENS. Pkway</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lactecesia</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Primary Pleuric</u>			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20a INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 7</u> , 19 <u>67</u> to <u>12/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>67</u> , and that death occurred at <u>3:50</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.		22b. DATE SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d ADDRESS <u>ROCKVILLE, MD. 20852</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12-16-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK</u>	23d LOCATION (City or town) (County) (State) <u>FALLS CHURCH, VA.</u>
24 FUNERAL DIRECTOR <u>F.J. COLLINS</u>		25a REC'D BY REGISTRAR <u>3821-14th ST. N.W. D.C.</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 18 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

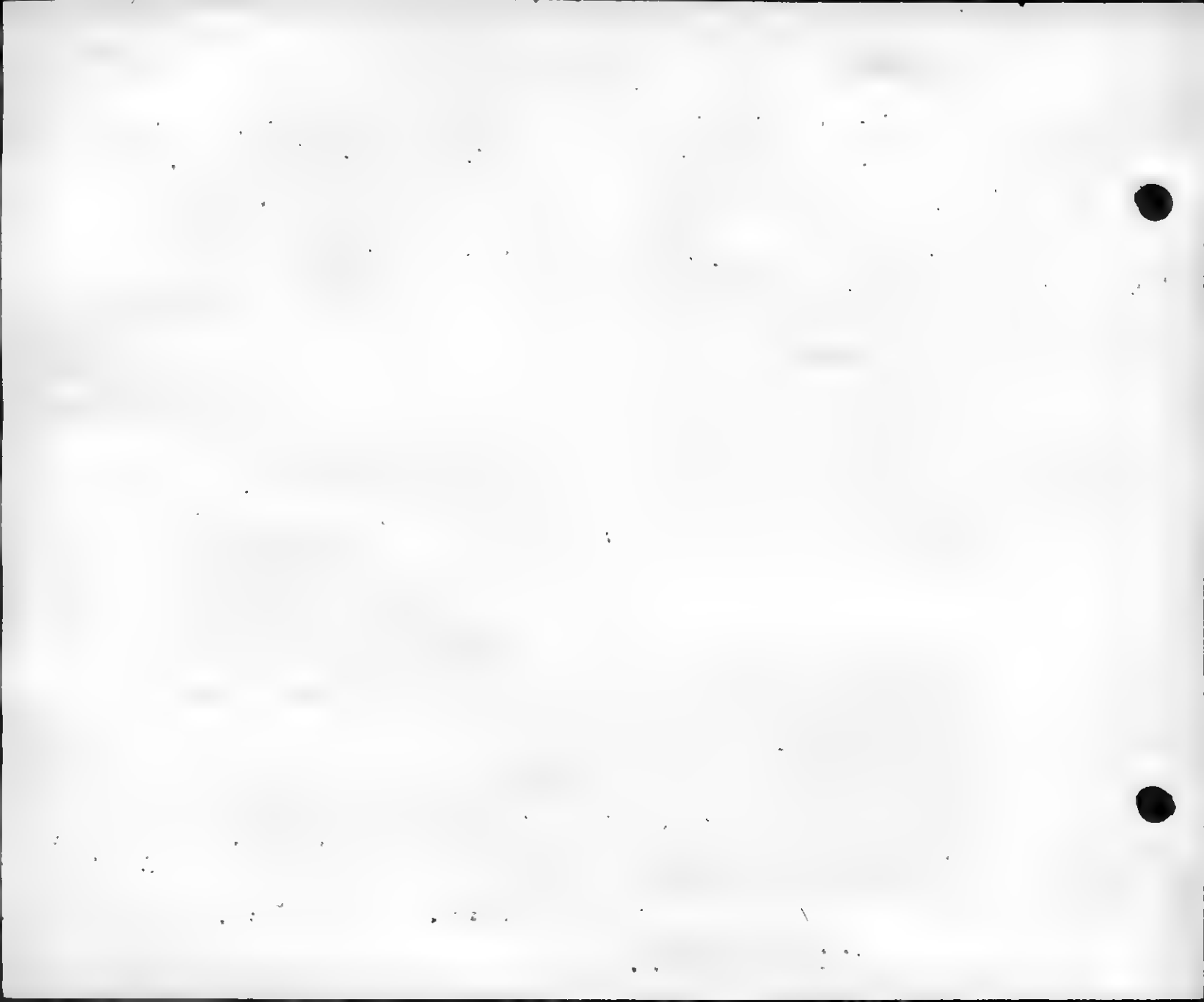
CERTIFICATE OF DEATH

17401

1. DECEASED-NAME (Type or print) <u>FLORIANE HENDERSON WHEELER</u>			2a. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1967</u>			2b. HOUR <u>10:15 PM</u>		
3. SEX <u>Female</u>		4. RACE <u>CAUC.</u>		5. DATE OF BIRTH <u>4-21-1878</u>		6. AGE (In years last birthday) <u>89</u> YRS.		
7a. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Pr Geo To Md.</u>		
10. CITY OR TOWN OF DEATH <u>WHEELER</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>UNIVERSITY NURSING HOME</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOME MAINT.</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>INDIANA</u>			13b. COUNTY <u>INDIANA</u>		13c. CITY OR TOWN <u>WHEELER</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <u>Unknown</u> Middle <u></u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>555-09-500</u>		17. INFORMANT <u>NURSING RECORDS</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Insufficiency</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY Hour <u></u> A.M. Month <u></u> Day <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> , to <u>12-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 24</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Robert Kramer M.D.</u>						22c. DATE SIGNED <u>12/24/67</u>		
22d. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>						22e. ADDRESS <u>8484 16th ST. SS Md.</u>		
23a. SPECIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>12/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pr Geo To Md.</u>		
24. FUNERAL DIRECTOR <u>W. H. Huntemann & Son Funeral Home</u> <u>5732 Georgia Ave N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN TB 17 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oak Haven Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum d. STREET ADDRESS 625 Sheridan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE First Cona Middle WHELAN Last F SEX wh. 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 26, 1983 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months 29 Days 19 Hours 67 Min.		4. DATE OF DEATH DEC 29 1967 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Cleaner 10b. KIND OF BUSINESS OR INDUSTRY District Govt. 11. BIRTHPLACE (County & State, or foreign country) Georgetown, DC 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 217-52-8293 17. INFORMANT Wallace F. Whelan-12717-Rigdale Ter. S. S. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Chronic Bronchitis DUE TO (b) Coronary Arterio-sclerotic syndrome DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I of 19 St. showed progressive deterioration and died of Terminal Pneumonia 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
21. I certify that (I) (this hospital) attended the deceased from July 9, 1966 to 12/29, 1967, that (I) (we) last saw the deceased alive on 12/27, 1967, and that death occurred at 6 P.M. from the causes and on the date stated above. 22a. SIGNATURE R. S. Williams M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) R. S. WILLIAMS 22d. ADDRESS 35 NEW YORK AVE. NW 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan 3, 1968 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 23d. LOCATION (City, town or county) (State) Washington, DC 24. FUNERAL DIRECTOR'S SIGNATURE C. Glen Carter ADDRESS 8434 Ga. Ave 25a. REC'D BY REGISTRAR JAN 9 1968 25b. REGISTRAR'S SIGNATURE Charles Jones			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17402

17403

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and have them filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

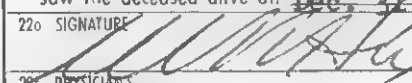

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY in 1b 1 yr. 5 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 4977 Battery Lane, Apt. XXXX e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle H. Last White		4. DATE OF DEATH Month Dec. Day 16, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1895 9. AGE (In years last birthday) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hanson		14. MOTHER'S MAIDEN NAME Lizzie Swenson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578-12-5580A	
17. INFORMANT Husband Address Lincoln White		Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA DUE TO (b) CEREBRAL ATROPHY DUE TO (c) MASSIVE C.V.A.'s Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 10 days 1 1/2 yrs 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 20, 1949 to DEC 16, 1967 , that (I) (we) lost saw the deceased alive on Dec. 11, 1967 , and that death occurred at 7:23 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. DATE SIGNED Dec. 16, 1967	
22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE		22d. ADDRESS 5009 Del Ray Ave. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-18-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION (City or town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



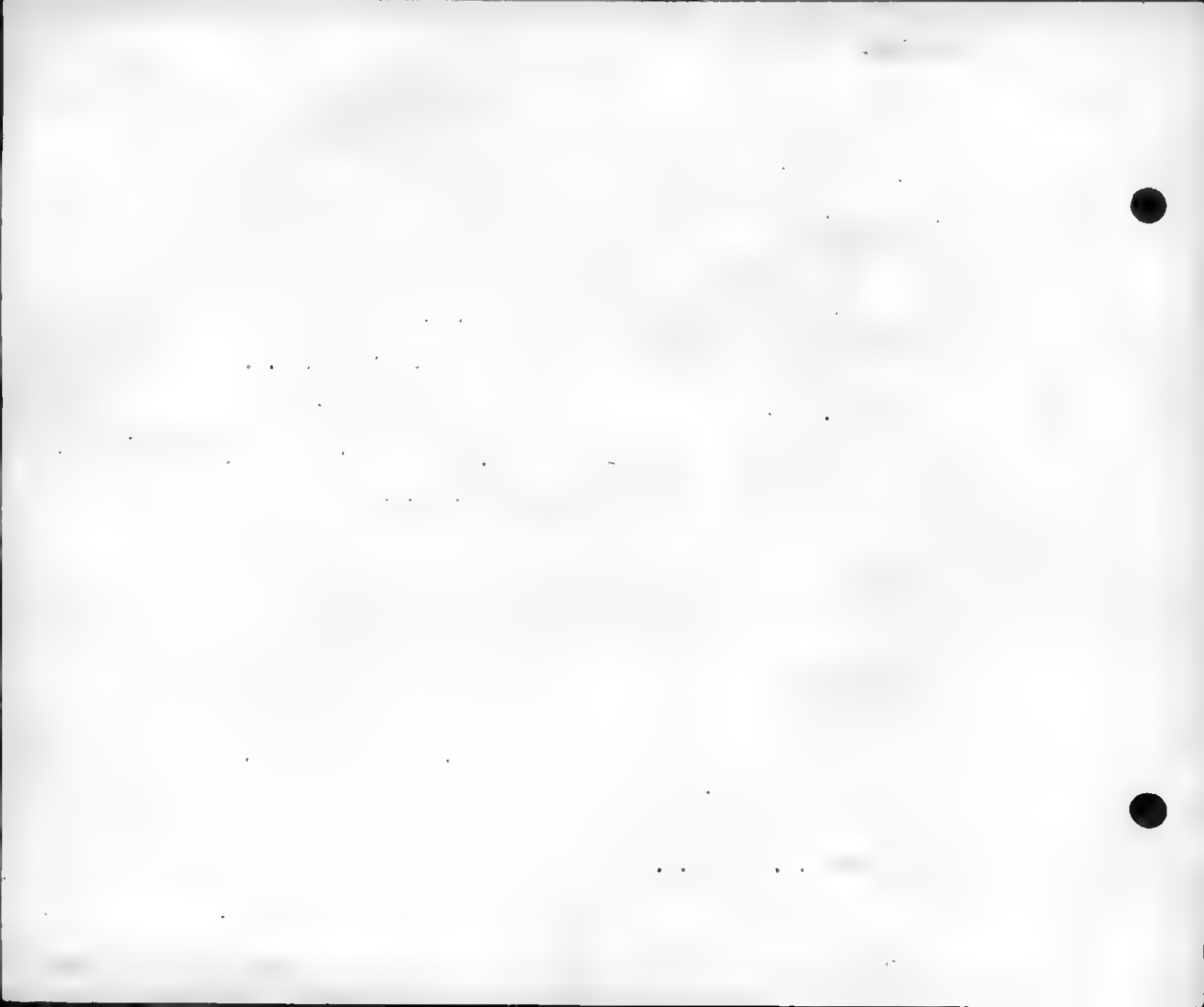
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17404

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale		d. STREET ADDRESS 4509 Old Columbia Pike	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Lloyd		Middle Franklin		Last WHITE		Month December Day 31 Year 19 67	
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1906	
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.		11. BIRTHPLACE (County & State, or foreign country) Johnson County, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas L. White				14. MOTHER'S MAIDEN NAME Bessie Guthridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1927 to 1957				16. SOCIAL SECURITY NO 224-52-3231		17. INFORMANT Mrs. Eleanor White	
				Annandale, Va. 4509 Old Columbia Pike			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVA. BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 576X Acute Suppurative Peritonitis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 2 , 19 67 , to Dec. 31 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 31 , 19 67 , and that death occurred at 1155A , from causes and on the date stated above.							
22a. SIGNATURE 						22b. DATE SIGNED 31 DEC 67	
22c. PHYSICIAN'S NAME (Type) W.R. Hix, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Everly-Wheatley				25a. REC'D BY REGISTRAR JAN 8 1968		25b. REGISTRAR'S SIGNATURE 	
1500 West Broad Rock Road Alexandria, Virginia							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



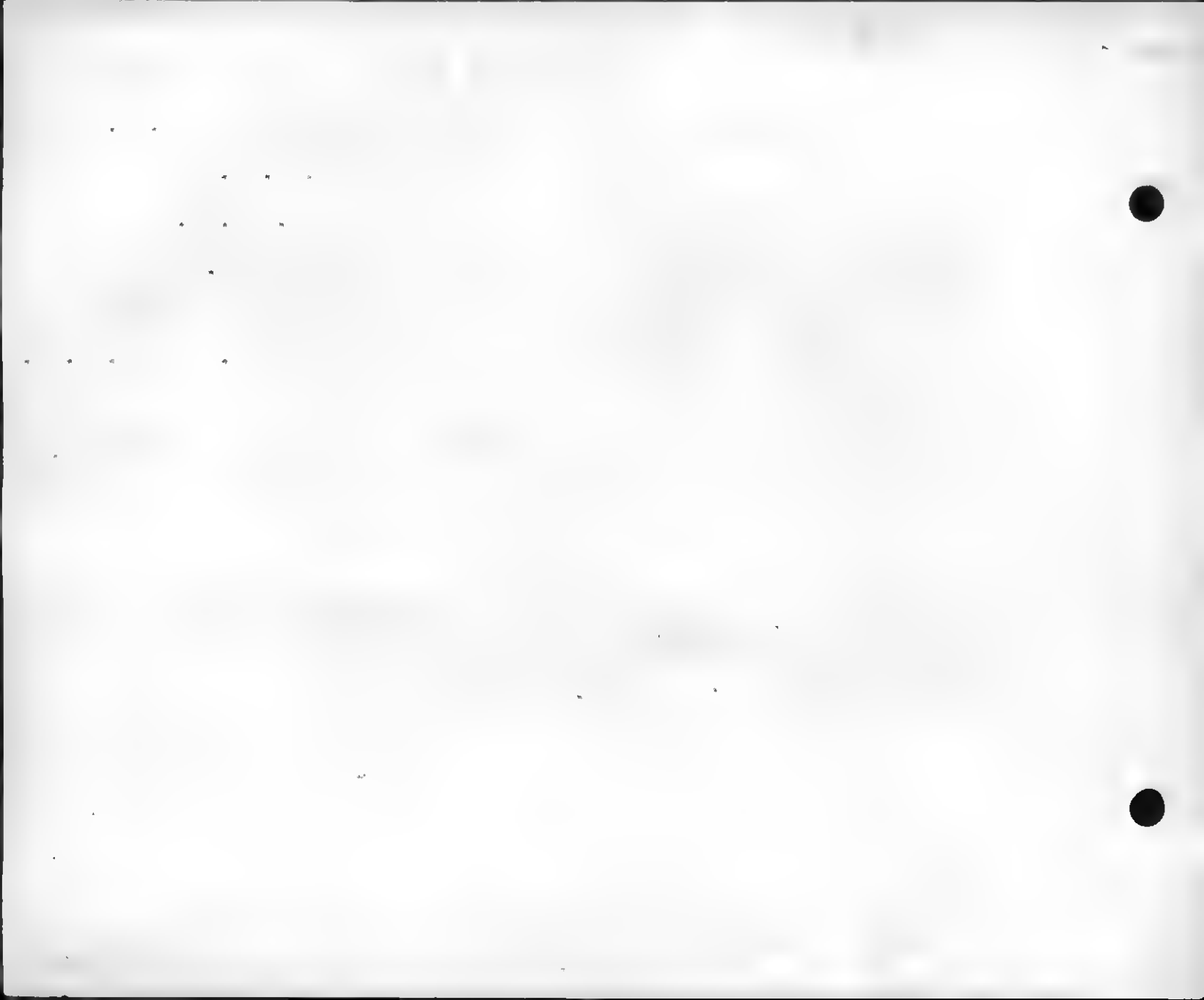
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17405

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN IS 3 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 4301 Warren St., N. W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Agnes Middle Virginia Last Williams		4. DATE OF DEATH Month Dec. Day 30 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 18 1886
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY At Home	
12. BIRTHPLACE (County & State, or foreign country) Fredericksburg Va.		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME Sanford Allen		15. MOTHER'S MAIDEN NAME Sarah Henderson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes give war or dates of service) No		17. SOCIAL SECURITY NO 223 66 8344	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIAL SCLEROTIC HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2+ days WEEKS YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GEN'L ARTERIO SCLEROSIS UREMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) D. N. A.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/9 1967 , to PRES , that (I) (we) last saw the deceased alive on 12/29 1967 , and that death occurred at 3 A M , from causes and on the date stated above.			
22a. SIGNATURE Charles Savarese, M.D.		22b. DATE SIGNED 12/30/67	
22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE, M.D.		22d. ADDRESS 11125 ROCKVILLE PK, ROCKVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Mt View Baptist	23d. LOCATION (City or Town) (County) (State) King George Cty Md
24. FUNERAL DIRECTOR Robert A Pumphrey		25a. REC'D BY REGISTRAR 7557 Wisconsin Ave Bethesda, Md	
25b. REGISTRAR'S SIGNATURE John J. Judge		DATE JAN 5 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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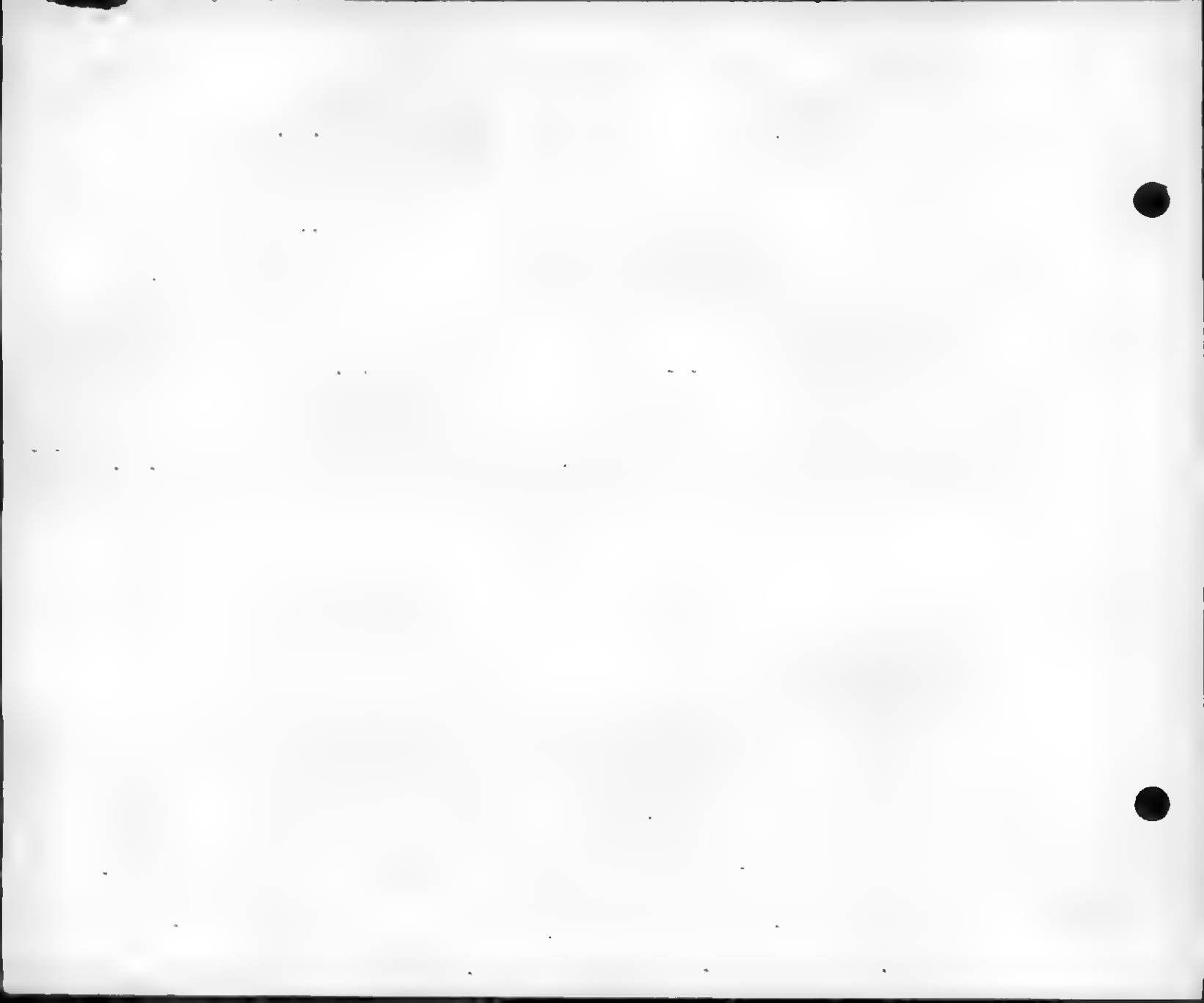
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY in lb <u>2 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>Washington, D. C.</u>		b. COUNTY <u>Washington, DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>				e. STREET ADDRESS <u>5922 13th St., NW</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie Franklin Williams</u>						4. DATE OF DEATH Month Day Year <u>12/9 19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/26/1894</u>		9. AGE (In years last birthday) <u>73 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. School Dist.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ida Liza Lecture</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>197-09-4332</u>		17. INFORMANT <u>Gertrude Williams</u> Address <u>5922 - 13th Street, N.W., Washington, D. C.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma</u> (c) <u>onset two years -</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-7</u> , 19 <u>67</u> , to <u>12-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Myron L. Lenkin</u> M.D.						22b. DATE SIGNED <u>12-9-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Myron L. Lenkin</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24a. FUNERAL DIRECTOR <u>C. Glen Carter</u>				24b. ADDRESS <u>434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24c. FUNERAL HOME <u>Warner E. Humphrey, Inc.</u>				24d. ADDRESS <u>Silver Spring, Md.</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

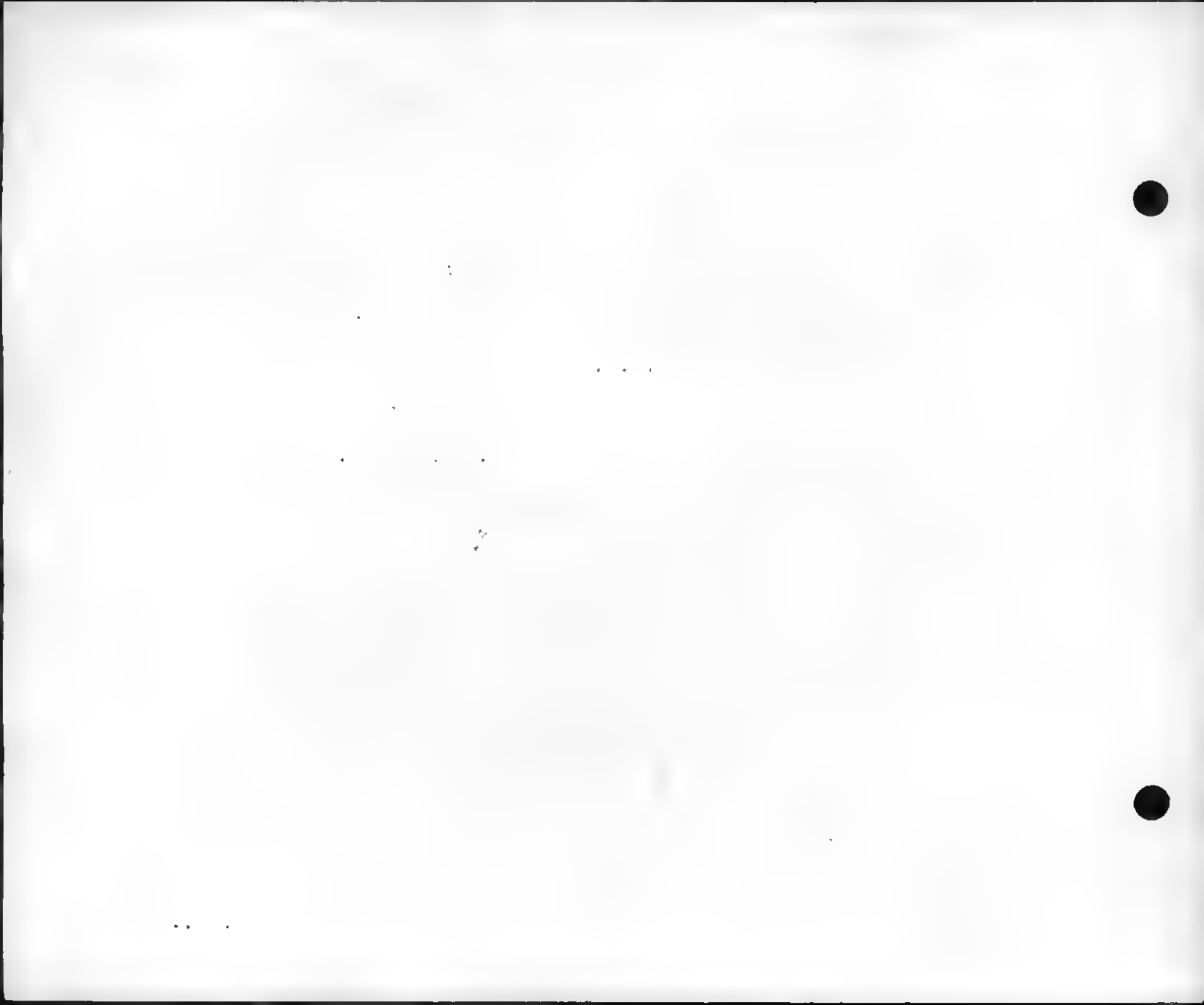
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17407

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Carver Rd.</u>		d. STREET ADDRESS <u>25 Carver Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>E.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Fe.</u>	6. COLOR OR RACE <u>Colord.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1916</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Montvale, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Charles E. Williams</u>		Address <u>25 Carver Rd., Cabin John, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>465X</u> IMMEDIATE CAUSE (a) <u>Pulmonary infarction, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Ball</u> EXAMINER'S NAME (Type)		22. DATE SIGNED <u>12/20/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montvale, Va.</u>
24. FUNERAL DIRECTOR <u>Montvale Fun. Soc. Inc., 1520 North St., N.W., DC</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

cleared with MEDICAL EXAMINER

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Montgomery				Maryland			
Silver Spring				Silver Spring			
575 Thayer Avenue				575 Thayer Avenue			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
EMMA KATE WILT				12 27 1967			
5. SEX				6. DATE OF BIRTH			
Female				6/25/1883			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday)			
Caucasian				84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
Housewife				Pennsylvania			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
E. M. Abraham				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
No				220-54-0177			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				17. INFORMANT			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				Mrs. Ruth Holland			
DUE TO				Same as #2 above			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Interval between onset and death			
(b) Acute Myocardial Infarction				immed.			
(c) Atherosclerotic Cardiovascular Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):				19. WAS AUTOPSY PERFORMED?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from. April 1967 to Dec 1967 that (I) (we) last saw the deceased alive on Dec 26 1967 and that death occurred at 7 AM, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Bernard A. Fitzgerald				12-27-67			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
BERNARD A. FITZGERALD				2174 MU. BLVD E, SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				12/30/67			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Sylvan Heights Cemetery				Uniontown, Pennsylvania			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Joseph Gawler's Sons, Inc., Washington, D. C.				25b. REGISTRAR'S SIGNATURE			
				DATE JAN 3 1968			



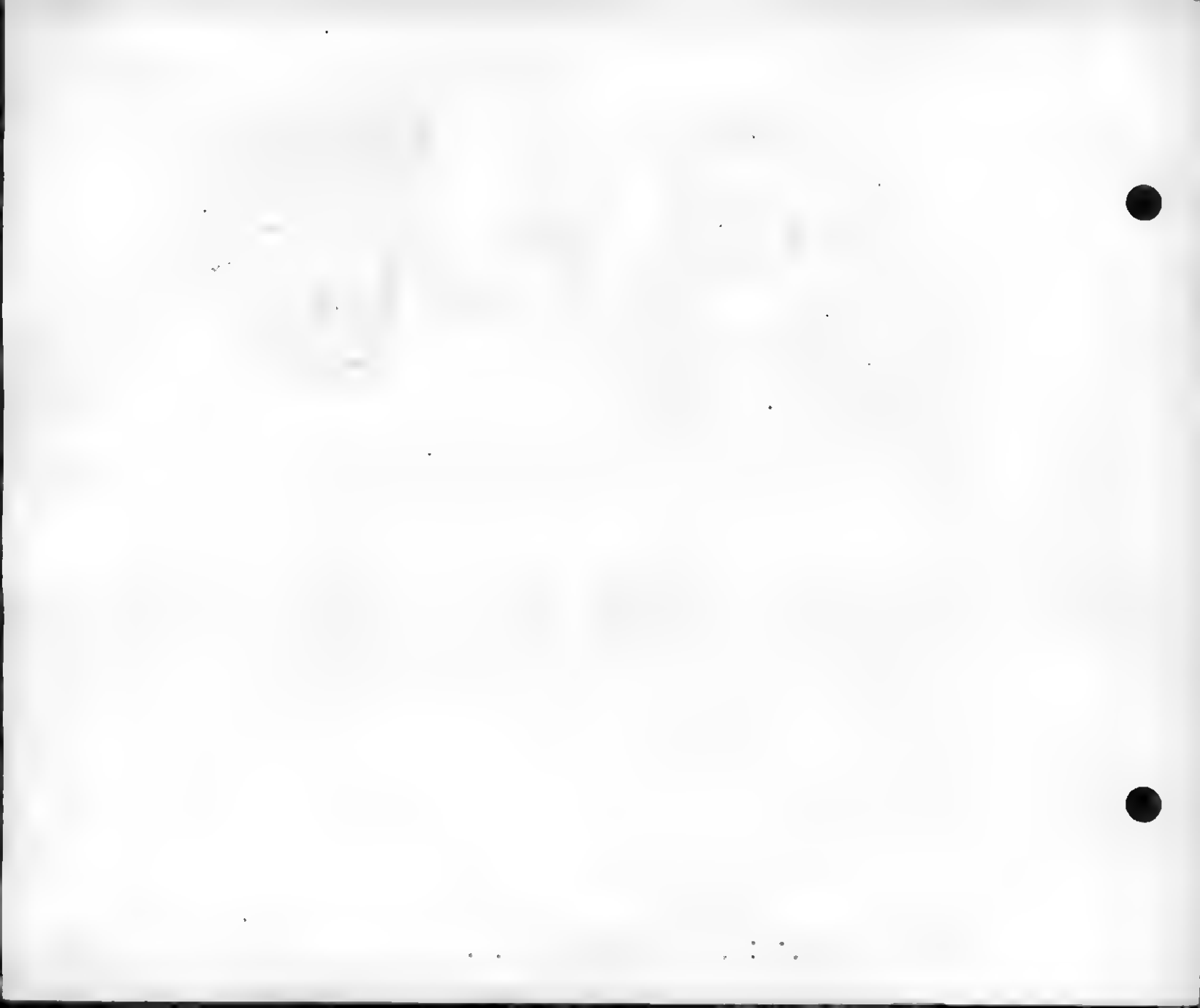
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>7904-16th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Merle K. Wood</u>		4. DATE OF DEATH <u>December 25th 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 30, 1898</u>
9 AGE (In years last birthday) <u>69</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Federal employee</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>New York</u>	
13 FATHER'S NAME <u>Horace H. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Kuhn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>579-60-1466</u>	
17 INFORMANT <u>Ruth R. Wood same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cerebrovascular disease</u> (b) <u>of arteries</u> (c) <u>10 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <u>11/23, 1967</u> to <u>12/25, 1967</u> that (I) (we) last saw the deceased alive on <u>12/24, 1967</u> and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>12/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. Kreuzburg</u>		22d. ADDRESS <u>7852 16th New Deal Dr</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <u>Toledo, Ohio</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
2901 14th St. N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
		DATE <u>DEC 27 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Mrs. Rap - 12-24-67 / 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Mary Kensington b. COUNTY Montgomery Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Silver Spring Holy Cross Hospital		d. STREET ADDRESS 3912 Wabington St.	
3. NAME OF DECEASED (Type or print) Martin First Herbert Middle Wright Last		4. DATE OF DEATH Month 12 Day 24 Year 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 31 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		11. BIRTHPLACE (County & State, or foreign country) Washington, DC	
13. FATHER'S NAME Herbert Wright		14. MOTHER'S MAIDEN NAME Elva Manning	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes or unknown) (If yes give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO. 218 05 6066	
17. INFORMANT Ethel W. Wright same item # 2-wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Chronic myocardial infarction DUE TO (c) Chronic arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1948 , to 12-24, 1967 , that (I) (we) last saw the deceased alive on Nov 1967 , and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE J.S. Rogers		22b. DATE SIGNED 12-24-67	
22c. PHYSICIAN'S NAME (Type) J.S. Rogers		22d. ADDRESS 1919 Seminary Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/28/67	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville, Md.
24. FUNERAL HOME Johnson Funeral Home - 1330 Rockville Pike		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE John M. Judge		DATE 12-24-67	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17410

CERTIFICATE OF DEATH

17411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>18 mos.</u>				d. STREET ADDRESS <u>11931 Viers Mill Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11931 Viers Mill Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James ROBERT Zehner</u>				4. DATE OF DEATH <u>Dec. 18 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/19</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anderson, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gloyd Zehner</u>				14. MOTHER'S MAIDEN NAME <u>Irene Sandifer Shaffer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II - Korea</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Margaret Zehner</u> Address <u>11931 Viers Mill Road Wheaton, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>2 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm; factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>Dec 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 17 1967</u> , and that death occurred at <u>3:57</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack MD</u>				22b. DATE SIGNED <u>12/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>	
22d. ADDRESS <u>4115 Colie Dr. Wheaton, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Dec. 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Warner Clark & Son, Inc.</u>	
25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>				25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

